

6th edition



AN INTRODUCTION TO

# Counselling and Psychotherapy

THEORY, RESEARCH AND PRACTICE

John McLeod



# **An Introduction to Counselling and Psychotherapy**





# **An Introduction to Counselling and Psychotherapy Theory, Research, and Practice**

**Sixth Edition**

**John McLeod**



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# PRAISE PAGE

***“Professor John McLeod’s Introduction to Counselling and Psychotherapy is a classic text. In providing a comprehensive perspective on the field, it goes well beyond being a mere ‘introduction’. Not only does it deliver an encyclopaedic amount of information, but it also presents this information in an incredibly captivating manner. There is simply no other book on the topic to match it. This new edition, truly faithful to its predecessors, maps new innovations in the context of previous generations’ viewpoints. This is ‘the’ book on counselling and psychotherapy.”***

*Ladislav Timulak, PhD, Course Director,  
Doctorate in Counselling Psychology, Trinity College Dublin*

***“John McLeod has a talent for bringing readers into intimate contact with the experience of another person’s experience. Through his evocative descriptions, accessible language, and plentiful examples you will find yourself looking through the eyes of both clients and therapists and developing a depth of understanding about important processes in psychotherapy. His position at the vanguard of psychotherapy research allows him to bring to life the practice of psychotherapy while posing research questions and stimulating curiosity about findings. His valuing of varied approaches to psychotherapy invites the reader to connect with diverse perspectives and consider their own beliefs.”***

*Heidi M. Levitt, PhD, University of Massachusetts Boston, USA*

***“I highly recommend this book for anyone wanting to learn about counselling and psychotherapy. The writing is scholarly, accessible, and well researched. John McLeod is an excellent theoretician, researcher, and scholar.”***

*Clara E. Hill, Department of Psychology, University of Maryland, USA*

***“Once again this core text has been impressively updated. It is an engaging and comprehensive introduction to the theory and practice of counselling, and I was particularly pleased to see the updated sections on social justice and the sociopolitical climate in which therapy is situated. This is a timely and important addition to a classic book.”***

*Laura Winter, Senior Lecturer in Education and Counselling Psychology,  
Manchester University, UK*

***“In this superb book, John McLeod achieves an extraordinary feat: a work that is a real pleasure to read and also a serious education for beginning and experienced practitioners alike. Organised into four thoughtfully chosen sections, McLeod offers an erudite, comprehensive, carefully referenced discussion of the philosophy, history, theories and practice of counselling and psychotherapy within the social, political and cultural context of the twenty-first century. As we would expect from McLeod, everything is respectfully treated and relevantly grounded in research findings. Then, in addition to all this, he gives us a really ‘good read’ – accessible, practical and human, full of useful examples and challenging invitations to question oneself and one’s assumptions.***

***I recommend it to us all.”***

*Professor Charlotte Sills, Psychotherapist, Coach, Supervisor,  
Metanoia Institute and Ashridge Business School, UK*

***“This 6<sup>th</sup> edition is a huge achievement. Encyclopaedic in scope, it builds on the well-established strengths of previous editions. Each chapter illustrates the development of counselling and psychotherapy with some new and extremely rich, contemporary examples. Essential reading for students and practitioners, I would particularly highlight the sections on social justice.”***

*Jeannie Wright, Visiting Professor,  
Dept of Counselling, University of Malta*

***“John McLeod’s ‘An Introduction to Counselling and Psychotherapy: Theory, Research, and Practice’ (6<sup>th</sup> Edition) achieves a masterful balance of scope, clarity, and engagement. The book will prove an outstandingly valuable resource for clients, students, and advanced practitioners. It contains a comprehensive treatment of key foundational knowledge in the field, relevant research, clinical theory, and illuminating case examples. Readers will find this book an informing and thought provoking read on all aspects of psychotherapy and counselling practice. McLeod offers specific chapters on current sensitive issues, including the embodied aspects of experience and change, the importance of nature, spirituality, politics, culture and social justice, with timely attention paid to socio-cultural, under-represented groups’ issues. McLeod pours his wisdom and experience into a work of enormous importance for our field and its complex applications in daily practice. For those in the helping professions, this book is a must read.”***

*Beatriz Gómez, PhD and Alejandro Pawliszyn, MS MA Lic,  
Aiglé Foundation, Argentina.*

***“John McLeod possesses a depth of knowledge and enlightened understanding of counselling and psychotherapy, fine-tuned over a career of teaching, research, practice and writing. This updated, restructured and expanded 6th edition presents a comprehensive, accessible and thought-provoking account of the field. The personal in the professional is enhanced by the inclusion of societal and political influences which pose both challenges and possibilities to practitioners.***

***This is by far the most important, insightful, profound and engaging book of its kind and is an essential reading and reference resource for students, accredited therapists and educators alike.”***

*Dr Marcella Finnerty, President, Institute of Integrative  
Counselling and Psychotherapy, Dublin, Ireland*

***“So much more than an ‘introduction’. . . This is one of the great and defining textbooks in our field: continually evolving and presenting a comprehensive, contemporary, and in-depth review of counselling and psychotherapy theory and practice. John offers a radical, progressive vision of what counselling can be: right from his new first chapter on ‘What it’s like to be a client’. This book is an invaluable resource both for new trainees coming into the field, and for seasoned practitioners wanting to understand who we are and where we are going.”***

*Mick Cooper, Professor of Counselling Psychology,  
University of Roehampton, UK*

## **Dedication**

For Julia

# Brief Table of Contents

<b>Part 1 What happens in therapy: the common ground</b>	<b>1</b>
1 What it's like to be a client	3
2 What it's like to be a therapist	13
3 Building a therapeutic relationship: working together	27
4 The process of therapy: the beginning	46
5 The hard work: choices, learning, and change	62
6 Leaving therapy	83
<b>Part 2 Conceptualising the practice of therapy</b>	<b>91</b>
7 The psychodynamic tradition	93
8 The cognitive-behavioural perspective	116
9 Interpersonal therapies	142
10 Person-centred, humanistic, and experiential approaches	150
11 Transactional analysis: a comprehensive theoretical system	171
12 Gestalt therapy	185
13 Existential therapy	195
14 Narrative approaches to therapy	208
15 Working with families	229
16 The use of art in therapy	240
17 Therapy in nature: using the outdoor environment	252
18 Religion and spirituality	259
19 Embodied conversations: implications of developmental neuroscience and other biologically informed perspectives	270
20 Integrative therapies	281
21 Pluralistic therapy	299
<b>Part 3 Therapy as a response to cultural difference and social adversity</b>	<b>317</b>
22 The historical context of contemporary practice	319
23 Culturally sensitive therapy	338
24 Therapy and the social	362
25 Gender and sexuality	376
26 A social justice orientation: therapy as political action	395
<b>Part 4 Being a therapist</b>	<b>407</b>
27 The qualities of effective therapists	409
28 Professional structures for supporting therapist competence	425
29 Working within an ethical and moral framework	445
30 Using research to inform practice	470
31 Making use of different delivery formats to enhance access and effectiveness	495
32 Looking ahead: future challenges for the psychotherapeutic professions	524
<b>Bibliography</b>	<b>533</b>
<b>Index</b>	<b>665</b>

# Detailed Table of Contents

<b>List of figures and tables</b>	<b>xix</b>		
<b>How to use this book</b>	<b>xx</b>		
<b>Acknowledgements</b>	<b>xxii</b>		
<b>Part 1 What happens in therapy: the common ground</b>	<b>1</b>		
<b>1 What it's like to be a client</b>	<b>3</b>		
Introduction	3		
Getting started	4		
Getting involved	5		
Making connection	6		
Doing the work	7		
Ending therapy	8		
Evaluating therapy	9		
Coming back for more	11		
Conclusions	11		
Suggested further reading	12		
<b>2 What it's like to be a therapist</b>	<b>13</b>		
Introduction	13		
What therapy tries to achieve	14		
What therapists do	15		
General principles	15		
A place to talk	15		
A therapeutic space	17		
A way of being	17		
A supportive relationship	18		
Making sense of complex problems	19		
Staying safe	19		
Specific therapist practices	20		
Micro-skills	20		
Interventions and techniques	22		
The experience of being a therapist	24		
Conclusions	25		
Suggested further reading	26		
<b>3 Building a therapeutic relationship:     working together</b>	<b>27</b>		
Introduction	28		
Making sense of the therapeutic re- lationship: multiple perspectives	28		
		The relationship as container	28
		The relationship as a place of authentic meeting	29
		Therapist as teacher or coach	30
		The author–editor relationship	30
		Therapist and clients as allies	31
		Maintaining mutual alignment	31
		Integrative models: the all-purpose therapeutic relationship	31
		The responsive relationship	31
		The five relationship model	32
		Josselson's multi- dimensional model	32
		Structural analysis of social behaviour	33
		Reflecting on images of the therapeutic relationship	33
		The client's internalisation of the therapist	34
		Relational depth	35
		Building a therapeutic relationship	36
		Small ways in which a relationship is built	36
		Shared language	37
		Unconscious synchrony	37
		Metacommunication	38
		Repairing ruptures in the alliance	38
		The embodiment of the therapeutic relationship	39
		Transition objects	39
		The therapy room	40
		The boundaried relationship	41
		Measuring the therapeutic relationship	42
		The financial relationship	43
		Conclusions	44
		Suggested further reading	45
		<b>4 The process of therapy: the beginning</b>	<b>46</b>
		Introduction	46
		Therapy as a process	47



A framework for understanding process	48	<b>6 Leaving therapy</b>	<b>83</b>
Conversation as the core process of therapy	49	Introduction	83
Starting therapy: practical issues	51	The experience of ending	84
Informed consent	51	Types of ending	85
Negotiating expectations and preferences	51	Unplanned endings	86
Preparation for therapy	52	Practical strategies for managing endings	87
Assessment	53	Preparing to end	87
Diagnosis	55	How therapists facilitate the process of ending	88
Agreeing goals	57	The impact of ending on the therapist	88
Case formulation and contracting	57	Conclusions	89
Introducing feedback measures	58	Suggested further reading	90
Starting therapy: the interpersonal process	59	<b>Part 2 Conceptualising the practice of therapy</b>	<b>91</b>
Conclusions	60	<b>7 The psychodynamic tradition</b>	<b>93</b>
Suggested further reading	61	Introduction	94
<b>5 The hard work: choices, learning, and change</b>	<b>62</b>	The origins of psychodynamic therapy: the work of Sigmund Freud	94
Introduction	62	The childhood origins of emotional problems	95
Change: gradual process or significant event?	63	The importance of the unconscious	96
Basic processes of learning and change in therapy	64	The concept of transference	97
Planned behaviour change	65	The main therapeutic techniques used in psychodynamic therapy	97
Dealing with internal conflicts	67	Building the psychodynamic tradition: key contributions	100
Openness to new experience	69	The early pioneers	101
Intensity, resoluteness, and courage	70	The Object Relations School	101
Finding what helps	71	The concept of projective identification	103
Micro-analysis of helpfulness	72	The 'real' relationship	104
The client's experience of what is helpful	73	The British Independents: the importance of countertransference	104
The client's experience of what is unhelpful	75	The American post-Freudian tradition: ego psychology and self-theory	105
Staying on track	76	The European tradition	106
Resolving impasses	76	Attachment theory	106
Using feedback	78		
The covert dimension of process: what is going on under the surface	80		
Conclusions	81		
Suggested further reading	82		

Brief psychodynamic therapy	110	Critical issues in CBT theory and practice	133
Psychodynamic-interpersonal therapy	111	The third wave: the flourishing of CBT	134
Dynamic interpersonal therapy	113	Dialectical behaviour therapy	135
Other forms of brief psychodynamic therapy	113	Acceptance and commitment therapy	135
Research into psychodynamic therapy	114	Motivational interviewing	136
Conclusions	114	Mindfulness-based cognitive therapy	137
Suggested further reading	115	Other third-wave approaches	137
<b>8 The cognitive-behavioural perspective</b>	<b>116</b>	Reflections on third-wave CBT	139
Introduction	117	Conclusions	140
The origins and development of the cognitive-behavioural approach	117	Suggested further reading	141
Applying behavioural concepts and methods in therapy	118	<b>9 Interpersonal therapies</b>	<b>142</b>
Systematic desensitisation and exposure	120	Introduction	142
The limitations of a purely behavioural perspective	121	The historical roots of interpersonal therapy	143
The emergence of cognitive approaches to therapy	121	Interpersonal psychotherapy	143
The practice of cognitive-behavioural therapy	124	Functional analytic psychotherapy	146
The therapeutic relationship: establishing rapport and creating a working alliance	125	Conclusions	149
Assessment: identifying and quantifying problem behaviours and cognitions	126	Suggested further reading	149
Case formulation: arriving at an agreed conceptualisation of the origins and maintenance of current problems	127	<b>10 Person-centred, humanistic, and experiential approaches</b>	<b>150</b>
Intervention strategies: the application of cognitive and behavioural techniques	128	Introduction	151
Monitoring: ongoing assessment of target behaviours	131	The philosophical and cultural underpinning of the humanistic therapies	151
Relapse prevention: termination and planned follow-up	132	The evolution of the person-centred approach	152
Research into the effectiveness of CBT	133	Theoretical framework of the person-centred approach	153
		The therapeutic relationship	155
		Empathy	156
		Congruence and presence	157
		The therapeutic process	158
		Experiential focusing	159
		Further developments in person-centred theory and practice	161
		Agency	162
		Self-multiplicity	162
		Relational depth	163

Mutuality	163	Research into the process and outcome of gestalt therapy	191
Strategies of disconnection	164	Emerging areas of application of gestalt therapy	192
Difficult process	164	Conclusions	193
Post-traumatic growth	165	Suggested further reading	194
Other humanistic therapies that build on the person-centred approach	165	<b>13 Existential therapy</b>	<b>195</b>
Expressive therapy	166	Introduction	195
Pre-therapy and contact work	166	Existential themes	196
Emotion-focused therapy	166	Being alone/being with others: isolation, autonomy, and relatedness	196
Humanistic counselling	169	Death/living in time	197
Links between the person-centred approach and other therapy traditions	169	Agency/freedom	198
Conclusions	169	Identity/embodiment	198
Suggested further reading	170	Meaning, truth, and authenticity	199
<b>11 Transactional analysis: a comprehensive theoretical system</b>	<b>171</b>	Existential therapy	199
Introduction	171	Basic principles of existential therapy	200
The theoretical foundations of transactional analysis	172	Existential therapy techniques	202
Basic assumptions	173	Existential therapy in action	204
Structural analysis	174	Existential therapy for sexual difficulties	205
Analysis of transactions	176	Existential therapy for long-term schizophrenia	205
Games	176	Conclusions	206
Life scripts	177	Suggested further reading	207
Transactional analysis in practice	179	<b>14 Narrative approaches to therapy</b>	<b>208</b>
The organisational structure of transactional analysis	181	Introduction	208
Using research to support new developments in TA therapy	182	Philosophical context	209
Reflections on transactional analysis	182	Narrative therapy	211
Conclusions	183	Externalising the problem	212
Suggested further reading	184	Enlisting community resources	214
<b>12 Gestalt therapy</b>	<b>185</b>	Therapist style	214
Introduction	185	The absent but implicit	215
Cultural and philosophical influences	186	Using audiences	215
Theoretical framework for practice	188	Visual and metaphoric modes of storytelling	216
Gestalt strategies for facilitating awareness and change	189	Working with communities	216
		Research on narrative therapy	217
		The significance of narrative therapy	218

Other narrative-informed approaches to therapy	218	Art as a way of making sense of therapy	249
Constructivist therapy	219	Art as a means of communicating the findings of research	249
Solution-focused therapy	221	Conclusions	250
Dialogical therapy	225	Suggested further reading	251
The radical theatre tradition	226		
Conclusions	227		
Suggested further reading	228		
<b>15 Working with families</b>	<b>229</b>	<b>17 Therapy in nature: using the outdoor environment</b>	<b>252</b>
Introduction	229	Introduction	252
Understanding human systems	230	The health benefits of being in an outdoor environment	253
Theoretical traditions within family therapy	231	Forms of outdoor therapy	253
Family therapy techniques	233	Ecopsychology	253
Reframing	234	Adventure/wilderness therapy	254
Questioning	234	Nature therapy	255
Using genograms to explore family patterns across generations	234	Horticulture therapy	255
Enactments	235	Animal-assisted therapy	256
Introducing new perspectives: reflecting teams	235	Taking ordinary talk therapy out of doors	256
Initiating change in the social ecology of the family	236	Political and social justice dimensions of outdoor therapy	257
Using rituals to create memorable change events	238	Research on outdoor therapies	257
Using feedback to promote collaboration and dialogue	238	Conclusions	257
Conclusions	239	Suggested further reading	258
Suggested further reading	239		
<b>16 The use of art in therapy</b>	<b>240</b>	<b>18 Religion and spirituality</b>	<b>259</b>
Introduction	240	Introduction	259
The therapeutic use of art: forms of practice	241	Spiritually and religiously informed therapeutic practice	260
Drawing, painting, and sculpting	242	Religion and spirituality as a resource	261
Photography	243	Therapy with members of specific religious faiths	263
Writing	243	Spiritual techniques in therapy	263
Music	245	Transpersonal psychotherapy	264
Drama	246	Therapist attitudes and competence in working with religious and spiritual issues	266
Other ways of using art in therapy	246	The dark side of religion and spirituality	267
Therapeutic processes associated with the use of art in therapy	247	Conclusions	268
		Suggested further reading	269

<b>19 Embodied conversations: implications of developmental neuroscience and other biologically informed perspectives</b>	<b>270</b>	Meta-theoretical integration	293
Introduction	270	Formulation-driven integration	293
Embodied therapy: older traditions	271	Disorder-based integrative approaches	293
Basic concepts	272	Personal or assimilative integration	293
Applications	272	Principle-driven integration	294
Paying attention to bodily processes	273	Unified psychotherapy	295
Interventions that reflect a neurobiological perspective	274	A common language for therapy	295
Theoretical perspectives	276	Collective integration	296
Risks of uncritical acceptance of a neurobiological perspective	278	Pluralism	296
Conclusions	279	‘Adapted’ approaches to therapy	296
Suggested further reading	280	Conclusions	297
<b>20 Integrative therapies</b>	<b>281</b>	Suggested further reading	298
Introduction	282	<b>21 Pluralistic therapy</b>	<b>299</b>
The underlying similarities across theories of therapy	282	Introduction	300
The movement towards integration	283	Philosophical context	300
The debate over the merits of integrated versus ‘pure’ approaches	284	The concept of pluralism	300
Strategies for achieving integration	285	The moral and ethical dimension of pluralism	301
Technical eclecticism	285	Ways of knowing	302
Common factors and the contextual model	287	The practice of pluralistic therapy	302
Theoretical integration: integrated approaches	288	Developing a shared understanding: theories as tools	303
Reality therapy	289	Shared decision-making	305
The Egan ‘skilled helper’ model	289	Information	306
Cognitive analytic therapy	290	Goals	306
The integrated psychotherapy model of Héctor Fernández-Álvarez	291	Tasks	307
Reflecting on integrated therapy	291	Methods	308
Theoretical integration: integrative approaches	292	Preferences	308
Modular/phased integration	292	Collaborative case formulation	308
		Maintaining alignment	309
		Interpersonal skills	309
		Metacommunication	309
		Feedback	310
		Facilitating learning and change	310
		Using existing therapy interventions	311
		Experiments	311
		Resources	312
		Dialogue	312

Pluralistic service delivery	313	The diversity of cultural beliefs and practices around how to handle problems in living	345
Training, supervision, and research	314	Culture-bound syndromes	345
Conclusions	314	Culturally diverse healing practices	346
Suggested further reading	316	Ritual healing: a Ndembu doctor	347
<b>Part 3 Therapy as a response to cultural difference and social adversity</b>	<b>317</b>	Counselling in the Chinese temple	347
<b>22 The historical context of contemporary practice</b>	<b>319</b>	Healing lament in Finland	347
Introduction	319	Naikan therapy in Japan	348
The social and historical origins of counselling and psychotherapy	320	Maori philosophy of life	348
The emergence of psychotherapy	321	Native American sweat lodge ceremonies	348
The establishment of psychiatry as a medical specialism	321	Implications of culturally diverse healing practices	349
The earliest forms of psychotherapy: hypnosis and psychoanalysis	323	Cultural identity and intersectionality	350
Therapy as a response to the loss of religious faith	325	Culturally sensitive therapy in action	351
Psychotherapy comes of age in the USA	325	General strategies	351
The recent history of psychotherapy	328	Cultural curiosity and humility	352
The emergence of counselling	330	Broaching: initiating conversations about cultural issues	353
The emergence of other professional identities	333	Ethnic/cultural client–therapist matching	354
Towards a transcultural history of therapy	335	Adapting or developing services and agencies to meet the needs of client groups from different cultures	357
Conclusions	335	Guidelines and competencies	359
Suggested further reading	337	Conclusions	360
<b>23 Culturally sensitive therapy</b>	<b>338</b>	Suggested further reading	361
Introduction	339	<b>24 Therapy and the social</b>	<b>362</b>
What do we mean by ‘culture’?	339	Introduction	363
The concept of reality	341	The social origins of personal problems	363
The sense of self	341	Conceptual frameworks for making sense of social disadvantage	364
The construction of morality	342	Social capital	365
The concept of time	342	Inequality	366
The significance of place	343	Weathering	366
Externally observable dimensions of cultural identity	344	Distancing	367
Overview: dimensions of cultural experience	345	Place	367



Social interventions	368	<b>26 A social justice orientation:</b>	
Generic social repair processes	368	<b>therapy as political action</b>	<b>395</b>
Constructing social solidarity:		Introduction	396
narrative therapy	368	Social justice as an overarching	
Using therapy to undo the effect		aim of therapy	396
of social degradation and		Being and becoming a social	
humiliation	368	justice-oriented therapist	397
Befriending	369	The concept of power	397
Social involvement initiatives	370	The concept of justice	398
Social matrix dreaming	370	Models of social justice therapy	
Prevention	371	practice	399
The significance of social class,		Self-awareness and training	399
social status, and poverty	372	Social justice therapy in action	400
The significance of affluence		Social action research	405
and privilege	374	Conclusions	405
Evaluating the social outcomes		Suggested further reading	406
of therapy	374		
Conclusions	374	<b>Part 4 Being a therapist</b>	<b>407</b>
Suggested further reading	375	<b>27 The qualities of effective therapists</b>	<b>409</b>
<b>25 Gender and sexuality</b>	<b>376</b>	Introduction	409
Introduction	376	Making sense of therapist	
The therapeutic significance		competence	410
of gender	377	Dimensions of therapist	
Gender-informed approaches		competence	411
to therapy	379	Ethical sensitivity	412
Feminist therapy	379	Interpersonal skills	412
The feminist critique of		Personal 'soundness'	414
psychotherapy theory and		An ability to draw constructively	
practice	380	on life experience	414
The emergence of feminist		The wounded healer	416
counselling and		Professional self-doubt/absence	
psychotherapy	381	of narcissism	417
Relational-cultural therapy	382	Conceptual ability	418
The development of a feminist		Mastery of technique	420
ethics for therapy practice	384	An ability to understand and	
The contribution of feminism		work within social systems	421
to counselling and		Openness to learning and inquiry	421
psychotherapy	385	Learning from exceptional	
Therapy for heterosexual men	386	therapists	422
Gender and sexual diversity	387	Conclusions	424
Therapy for sexual concerns	390	Suggested further reading	424
Abusive sexuality	392		
Conclusions	393	<b>28 Professional structures for</b>	
Suggestions for further		<b>supporting therapist competence</b>	<b>425</b>
reading	394	Introduction	426
		Training	426

Primary training	427	When the client is at risk of harming others	456
Acquiring a theoretical framework	428	When child protection is an issue	457
Counselling and interpersonal skills	428	When a therapist has an ethical responsibility to society as a whole	458
Personal development	429	Negotiating informed consent	458
Professional issues	430	How far should the client be pushed or directed? The use of persuasion, suggestion, and challenge	459
Supervised practice	430	Working within the limits of competence	461
Using research to inform practice	430	Managing boundaries	461
Preparation for lifelong learning	430	Multiple and dual relationships	462
Post-qualifying training/CPD	430	Sexual exploitation of clients	464
Supervision	431	Ethical issues involved in the use of touch	466
Enhancing therapist self-awareness	435	Ethical issues in research on therapy	467
Personal therapy	435	Strategies for maintaining ethical standards	467
Meditation	437	Legal considerations	468
Journaling	437	Cultural differences in ethical values and perspectives	468
Self-practice	438	Conclusions	468
Deliberate practice	439	Suggested further reading	469
Therapist well-being	440		
Career development	442		
Institutions	442		
Research	442		
Conclusions	443		
Suggested further reading	444		
<b>29 Working within an ethical and moral framework</b>	<b>445</b>	<b>30 Using research to inform practice</b>	<b>470</b>
Introduction	446	Introduction	471
Sources of ethical knowing	446	The historical development of research into counselling and psychotherapy	472
Personal intuition	447	The importance of methodological pluralism	474
Values	447	Research into the outcomes of therapy	474
Ethical principles	449	Client satisfaction studies	474
General moral theories	450	Randomised clinical/controlled trials	475
Ethical guidelines developed by professional organisations	451	Practice-based outcome studies	478
Human rights, entitlements, and capabilities	452	Therapy drop-out rates	479
Relational and process ethics	453	Behaviour change	480
Law	454	Cost-effectiveness	480
Research into professional ethics	454	Qualitative outcome research	480
Applying moral principles and ethical codes: from theory to practice	454	Outcome-oriented case studies	481
Confidentiality and accountability	455		



Surveys	481	Embedded counselling	507
Structural change	482	Self-help groups	508
Action research	483	Peers	509
Outcome research: reflection and conclusions	483	Therapeutic communities	509
Research into the process of therapy	484	Who is the client?	509
Studies of process from a client-centred perspective	484	Individuals	509
Studies of process from a psychodynamic perspective	486	Couples	510
The 'events paradigm'	486	Families	511
The process as experienced by the client: qualitative research	487	Groups	511
Case studies	489	Communities	512
Professional knowledge studies	491	Technologies	513
First-person research	491	Telephone	513
Ethical issues in therapy research	491	Internet	514
The relevance of research for practitioners	492	Self-help materials	517
The relevance of research for clients	492	Combining formats	520
Conclusions	492	Adjunctive interventions	520
Suggested further reading	494	Programmes and communities	520
		Stepped care	520
		Conclusions	522
		Suggested further reading	523
<b>31 Making use of different delivery formats to enhance access and effectiveness</b>	<b>495</b>		
Introduction	496	<b>32 Looking ahead: future challenges for the psychotherapeutic professions</b>	<b>524</b>
Time	497	Introduction	524
Frequency and length of sessions	497	Challenges within the world of counselling and psychotherapy	525
Long-term therapy	498	The future of counselling and psychotherapy as professions	526
Time-limited therapy	498	Challenges in the relationship between therapy and society	528
Intermittent therapy	500	Facing up to cultural difference	528
Single-session therapy	501	New technologies, new types of person	529
Place	502	Environmental collapse	529
Organisational contexts	502	The crisis within democratic processes and institutions	529
Who can be a therapist?	504	Conclusions	530
Professional therapists	504	Suggested further reading	531
Non-professional counsellors	505		
Low-intensity support workers	507	<b>Bibliography</b>	<b>533</b>
		<b>Index</b>	<b>665</b>

# List of Figures and Tables

<b>Figure 11.1</b>	Structure of personality	174
<b>Figure 11.2</b>	Second-order structural analysis	175
<b>Table 4.1</b>	Therapy process factors: an incomplete list	48
<b>Table 4.2</b>	Reasons for making a formal pre-therapy assessment	
<b>Table 5.1</b>	Stages in the assimilation of a problematic experience in therapy	53
<b>Table 14.1</b>	Comparison between a problem-focused and a solution-focused approach to therapy	224
<b>Table 24.1</b>	Categories of social adversity	364

# How to Use this Book

Therapy is, at its heart, a matter of talking to a concerned and interested listener about your problems. It is essentially a simple process, which has the potential to be helpful or even transformative because it activates basic human capabilities such as reflecting, meaning-making, planning, caring, having the courage to act, and the capacity to work together to generate new perspectives and creative solutions. At the same time, therapy is highly complex. In therapy, people talk about anything and everything. The relationship between a therapist and a person seeking help is simultaneously taking place at a physical, bodily level, through language, and in the thoughts, feelings, and memories of each participant. Counselling and psychotherapy, and related activities such as coaching and careers guidance, are informed by multiple traditions, academic disciplines, schools of thought, and programmes of research. Therapy is also delivered in many different formats: one-to-one, in couples, families, and groups, as well as on-line. It can comprise a single meeting or a lifetime of contact.

Reading a book like this is somewhat similar to looking through a window into a room filled with people. In the room, there are people doing something, but the true meaning of what they are up to is always on the other side of the glass. Therapy is a practical activity, and can only be grasped through the experience of doing it, as client and therapist. Real knowledge about therapy can never be gained through reading a book. It requires immersion in a live oral tradition, physically being there and doing it, and – crucially – *feeling* what is happening, rather than merely looking at words on a page. On the other hand, everyone – not just those who have participated in formal, contracted counselling or psychotherapy – has had the experience of being troubled and stuck, and using another person as a sounding board, empathic witness, and source of advice and support.

The aim of this book is to provide a comprehensive overview of as many aspects as possible of the rich array of ideas and practices that constitute contemporary counselling and psychotherapy. Within each topic, an attempt is made to offer enough information to give the reader an initial understanding of the issue, and then to provide suggestions for further reading through which that area may be explored in greater depth.

The book is written for three main groups of reader: clients and service users; trainee practitioners, such as trainee counsellors and psychotherapists in training; and qualified clinicians seeking to update their knowledge – but also anyone with an interest in learning more about therapy, such as doctors and social workers who refer individuals to therapy, or administrators and politicians who make decisions about the funding and management of therapy services.

Readers are encouraged to adopt a critical, questioning stance in relation to the field of therapy; theory and practice are placed within a historical, social, and political context; and the role of research and inquiry is reinforced throughout.

As with any other field of human-centred work, therapists build their practical knowledge through sharing stories from the frontline. This book therefore incorporates a thread of case studies or summaries, which present lived examples of therapy in action in different situations and informed by a range of methods and techniques. Each of these case summaries is taken from a published article where readers can access a more comprehensive account of how therapy unfolded in that instance.

## The book is organised into four sections:

*Part 1: What happens in therapy: the common ground.* The opening chapters of the book highlight processes and experiences that occur in all forms of therapy.

*Part 2: Conceptualising the practice of therapy.* One of the most striking characteristics of present-day therapy is the massive range of competing ideas that are in circulation around how to make sense of therapy, and how to provide the most effective therapy. The chapters in this section start with the ideas of Freud, and take the reader all the way through to newly developed innovative forms of therapy and emerging possibilities.

*Part 3: Therapy as a response to cultural difference and social adversity.* Therapy offers a benign and supportive relationship with another person that functions as an opportunity to recover from hurts inflicted by other relationships, and a way of learning how to connect with others in authentic and life-affirming ways. The chapters in this section unpack these key principles, in terms of how social adversity and cultural experience can produce wasted lives, and how various types of helping relationship and social action can make a difference.

*Part 4: Being a therapist.* The closing chapters explore a range of professional issues that are associated with being a therapist. The chapters in this section address such topics as: the qualities of effective therapists; ethical decision-making; organisational factors; different delivery systems; therapist training; supervision and professional development; making use of knowledge from research; and the capacity to take account of emerging issues and future challenges and possibilities.

At the end of each chapter there are questions for reflection and discussion, and information about recommended reading.

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# PART

# 1

# GROUND

## What happens in therapy: the common ground

There are many theoretical models that can be used to guide therapy, and many different formats within which therapy can be delivered. In some cases, therapy can continue for years – even a whole lifetime. In other cases, one or two meetings may turn out to be sufficient.

Behind and beneath this diversity, it is possible to identify a common ground, a set of processes and experiences that occur in all forms of therapeutic practice across all cultures. One of the landmark studies in the history of counselling and psychotherapy was the 1961 book *Persuasion and Healing: A Comparative Study of Psychotherapy* by Jerome Frank, an American psychiatrist and psychotherapist. In this work, Frank looked at the process of emotional healing in all cultures. What he found, everywhere he looked, was a sequence that began with a sense of demoralisation – faced with personal or interpersonal difficulties, the individual had tried but failed to resolve their problems using whatever support was at hand in their immediate social network. As a last resort, they sought the help of someone who was recognised and trusted within their culture as a ‘healer’. On entering the sacred or special space within which the healer operated, the person seeking help was invited to engage in a set of activities through which they were offered a rationale for their problems, were given hope that things would get better, and participated in rituals that allowed them to express previously suppressed emotions and acquire new strategies for coping. Frank argued that these universal processes could be observed just as much in healing ceremonies conducted by shamans in traditional tribal groups as in the offices of New York psychoanalysts.

The common ground of therapy also exists within everyday life, independent of the activities of socially sanctioned healers. Between children and adults, friends, lovers, colleagues, and many other types of relationships, it is not hard to observe people supporting each other – listening, offering wise guidance, sharing experience, crying and laughing, learning together, and solving problems. In the ordinary, everyday lives of all social groups can also be found a wide range of potentially therapeutic activities: music, art, dance, poetry, drama.

The term ‘common factors’ is widely used within the contemporary counselling and psychotherapy literature to refer to the kinds of healing process described in *Persuasion and Healing*. The decision to use an alternative image – the common *ground* – is an example of the values and critical perspective that inform this book. Factors are abstract entities that do not exist anywhere in the

real world. By contrast, the ground is something that all of us are in contact with, a shared, concrete reality that is always there.

There are six chapters in this section of the book. These begin by examining what it is like to be a client, a person using therapy to deal with problems in living. The focus then shifts to what it is like to be a therapist, and what therapists do, before moving on to consider how the shared efforts of client and therapists unfold over the course of therapy from start to finish.

# Chapter

# 1

## What it's like to be a client

<b>Introduction</b>	<b>3</b>
<b>Getting started</b>	<b>4</b>
<b>Getting involved</b>	<b>5</b>
Making connection	6
Doing the work	7
<b>Ending therapy</b>	<b>8</b>
<b>Evaluating therapy</b>	<b>9</b>
<b>Coming back for more</b>	<b>11</b>
<b>Conclusions</b>	<b>11</b>
<b>Topics for reflection and discussion</b>	<b>11</b>
<b>Suggested further reading</b>	<b>12</b>

### Introduction

The aim of this chapter is to anchor this book in the experience of what it is like to be a client in therapy. Most of the subsequent chapters are heavily dominated by a professional therapist perspective. Although clients and therapists need to work together, it is essential to acknowledge that they come from different places and have different agendas. The training and professional socialisation of therapists means that it is all too easy to lose sight of what the therapy room looks like from the other chair, even if it is, in all probability, a chair that they have sat in themselves.

Deciding to see a therapist is a major decision that for many is hard to do. Particularly when attending therapy for the first time, there can be a lot of anxiety around what will happen, possibly including a fear of being exposed and vulnerable. It can also be difficult to decide whether now is the right time to start therapy, and which therapist or therapy centre would be the best choice. Once therapy has commenced, there can be a lack of clarity about what one should be doing in order to get the most from the experience, and whether progress is being made. Therapy theories are predominantly formulated from the point of view of the therapist – the client or service user is viewed as someone to whom things are done. Fortunately, in recent years many research studies have been carried out in which people receiving therapy have been invited to describe their experiences and



evaluate whether their therapy has been helpful or otherwise. The present chapter draws on this body of research, and seeks to present an appreciation of what it can be like to be a client. The chapter is organised around the journey of a person through therapy, beginning with the experience of making a commitment to engage in therapy, through to looking back and reflecting on what it has all meant.

## Getting started

When a person is emotionally or psychologically troubled in some way, they tend to look around for accessible sources of help that seem credible and relevant (Marley 2011). A survey carried out by Jorm et al. (2000) found that most people are aware of a range of ways of dealing with problems such as anxiety and depression. Examples of widely used strategies include exercise, diet, getting out more, talking to friends and family, and taking time off work. Even severe problems can be addressed in a range of ways. For example, in one study, individuals who were struggling to control impulses towards suicide and self-harm found support, community, and practical advice in an on-line community (Baker and Fortune 2008). Most people are aware of counselling and psychotherapy, and medical treatment through going to their GP, as options that are available to them.

The decision to enter counselling or psychotherapy may sometimes be a response to pressure or encouragement from others. Research has shown that, overall, those who make an autonomous decision to go into therapy benefit more than people who are advised by someone else that they should do so (Zuroff et al. 2007). However, this is not as straightforward as it might seem. It is clear that, in some instances, encouraging a person to seek help comes from a genuinely loving and supportive place, whereas in others it may be controlling and even manipulative.

The type of therapy that is available will depend on a wide range of factors. For example, there tends to be a much wider choice of therapies in big cities than in rural areas. For many people, issues that influence their choice of therapist include practical matters such as cost, waiting lists, access to therapy at times they can manage, and childcare arrangements. Relatively few people are informed consumers of therapy, in terms of making a choice of therapist based on weighing up the pros and cons of the therapy approach used by different practitioners.

Therapists in private or independent practice usually provide information on-line about their credentials and experience, so that prospective clients can decide on a therapist that seems right for them. Some private practice therapists may offer an initial free or reduced-cost trial session, to enable the person to decide whether that therapist is the one for them. By contrast, counselling and psychotherapy agencies, and health service clinics, tend to allocate new clients to whichever therapist is available. Some clinics and services make it possible for a new client to choose the gender or age of their therapist, or allow them to move to another therapist if the one to whom they are first assigned turns out not to be a good fit. Where possible, someone choosing to see a therapist will make use of personal recommendations from friends, family members, work colleagues, and professional contacts, as a means of selecting a therapist or therapy agency.

One of the difficulties faced by anyone entering therapy is unclear expectations (Bury et al. 2007; Midgley et al. 2016). Even if the person decides on a well-known brand of therapy, such as cognitive-behavioural therapy (CBT), they still do not know what the CBT therapist they eventually meet will be like as a person. People often have ideas, images, and fantasies about therapy, gleaned from popular media, for example that they will be asked to lie on a couch, or that they will be hypnotised. At the same time, there is substantial evidence that people have preferences around what they think will be helpful or unhelpful for them (McLeod 2012; Walls et al. 2016), even if it can be hard for them consciously to articulate these beliefs at the start of therapy. The extent to which client preferences are actually fulfilled in therapy has been found to have a significant influence on how much benefit they report at the eventual completion of the therapy process.

Getting started in therapy typically involves some kind of initial contracting meeting, to clarify what the person wants from therapy, and to provide information on practical issues such as the length and timing of sessions, confidentiality, what to do if a session is missed, whether payment is required, procedures for responding to situations in which the person is at risk of harming self or others, and so on. This kind of information may also be available in a leaflet or web page. While necessary, this contracting stage of therapy can be quite awkward for some people, because they are not fully aware of what they are agreeing to, or because they are in a state of distress in which they urgently need help and support and someone to listen to their problems.

The whole 'getting started' phase of therapy can present an insurmountable hurdle and challenge for some people who are seeking help. As many as one in three people who make an appointment to see a therapist or access a therapy agency do not turn up for their first appointment. Of those who do turn up, a similar proportion never really engage with therapy, and quit within three sessions. The popularity of alternative means of accessing help, such as on-line therapy or using a self-help book or internet package, can be understood in part as a response to the potential embarrassment or shame of actually asking another person for help, face-to-face. On the other hand, some studies have found that people start to feel better as soon as they have made an appointment with a therapist or clinic, because they are heartened by the fact of having done something positive to address problems that may have been holding them back over a long period.

### Box 1.1: Consuming psychotherapy

Widely read book-length personal accounts of the experience of therapy have been published by Ann France (1988) and Anna Sands (2000). Each of these women worked with different therapists over periods of several years, and carefully describe the challenging and sometimes emotionally painful experience of becoming close to someone who is, in the end, responding to oneself in a professional role, using therapy theory to interpret what the client regarded as genuine feelings they were expressing towards the therapist. A further fascinating aspect of these accounts is that the writers were themselves knowledgeable about therapy theories and offer a running critical commentary of the inadequacy of these ideas from the point of view of the client. A useful appreciative summary and discussion of the valuable contribution of these authors can be found in House (2003). These books have been influential because they vividly demonstrate that the client perspective on therapy is quite distinct from that of the therapist. They also convey a sense that the outcome of therapy is never clear-cut. For both France (1988) and Sands (2000), the therapy they received was helpful in some ways, but in other respects was unsatisfactory or even, at times, harmful.

## Getting involved

Once the person arrives at the therapy room, two intertwined processes begin to take place. One process centres around the experience of being in a close but professional relationship with another person you meet on a regular basis for a period of uninterrupted time, and who listens to you in an intense manner, is closely interested in your life, learns your secrets, and on whom you may fairly rapidly come to depend as a source of support and guidance. The other process is concerned with the task of addressing the problems and difficulties that lead you to enter therapy in the first place, and knowing whether progress is being made around these issues. For many therapy clients, it is impossible to disentangle these elements – they are experienced as part of a seamless whole in which the process of resolving problems is something that arises from the shared effort of client and therapist

working together (Göstas et al. 2013). There is often a transition phase, as the person 'learns the ropes' of how to make use of the opportunity of being in therapy (Bury et al. 2007). Making use of therapy also calls for some rearrangement of everyday life, for instance by making a commitment to be at a certain place at the same time every week (Dreier 2008). The act of making a time and space for therapy can be helpful in itself. While they are in therapy, someone who is depressed and isolated is at least guaranteed an hour of intense contact with another person each week. A person who is stressed and over-busy has a week that is punctuated by a period of reflection and grounding. On the other hand, there can be negative aspects to the routine of therapy, such as family members feeling excluded from a significant area of the person's life.

## Making connection

An intrinsic aspect of the experience of being in therapy is that of meeting a stranger who will come to occupy a place in your life that is likely to be quite different to that of anyone else you have previously known. The therapist learns a lot about the client, but only what the client chooses to tell, or conveys unconsciously through body language or tone of voice. There are few opportunities for the therapist to directly observe the person going about their everyday business, or to acquire third-party information about them. On the other side, the person in therapy will almost certainly be highly curious about their therapist – what kind of a person are they really, and what kind of life do they live? Therapists tend to disclose little about such matters, so the client may be left reading as much as possible into whatever personal therapist information is transmitted during sessions, such as way of talking, style of dress, whether a wedding ring is being worn, items of religious faith, how the therapy room is decorated, and so on.

One way to make sense of the relationship between the client and the therapist is that it is about *making connection*. There is a connection in the moment – does the person feel that they are being listened to, being heard, and being understood? There is a connection over time – the person comes back week after week, and their therapist becomes part of the constellation of individuals who figure in their life.

An important aspect of making connection is the person's willingness to enter into a connection with a therapist. The instant impression that the person has, on meeting their therapist for the first time, can have a strong impact on everything else that follows. Sometimes a person 'just knows' whether a therapist is right or wrong for them (McMillan and McLeod 2006). The gender of the therapist can be highly significant for some people. Studies of gender matching in therapy have not arrived at any clear conclusions around whether having a same-gender or other-gender therapist is better. What does seem to be the case, however, is that therapist gender will carry some meaning for the person (Gehart and Lyle 2001; Kastrani et al. 2015), in terms of their openness to making connection, and the type of connection they are willing or able to establish. There are many other factors that can either facilitate or impede the early development of a sense of connection between client and therapist, such as sexual orientation, social class, or race and ethnicity. Underlying such factors, for many clients, is the question of whether they can trust the therapist with whom they will meet, or whether the therapist reminds them of, or acts in a similar fashion to, persons who have treated them poorly or abusively at earlier times in their life. Ward (2005) summarises this phase of therapy as comprising a period during which the client assesses and evaluates the therapist.

On the whole, therapists are fairly guarded about disclosing personal information to their clients, for example around such issues as their sexual orientation, whether they are married and have children, and so on. The rationale for this approach is that the purpose of therapy is to focus on the client, with the result that too much attention to the therapist would just get in the way. Nevertheless, many clients become interested in their therapist as a person, and are curious about what the therapist's life is like outside the therapy room (Lott 1999). Some clients may actively seek out information about their therapist, for example through social media.

In research interviews, many clients have reported that their capacity to connect with a therapist is only partially dependent on the skilfulness and competence of the clinician, and in many instances is more powerfully shaped by their kindness, way of dressing, and their non-verbal physical presence (Bedi et al. 2005; Pearson and Bulsara 2016). A consistent theme in client accounts of qualities of therapists with whom they have been able to form deep connection is that the therapist has been an authentic, genuine person, rather than someone performing a professional role (Chang and Berk 2009; Pugach and Goodman 2015). A further positive quality is that of being an ally who accompanies one through a period of change or transition in one's life (Binder et al. 2011).

## Doing the work

Once they have 'learned the ropes', and arrived at an understanding of how to make use of therapy (Poulsen et al. 2010), many clients describe the experience of being in therapy as 'hard work', in the sense that it is physically and emotionally exhausting (Bury et al. 2007; Göstas et al. 2013; Perren et al. 2009).

There are several strands of the work that can be particularly difficult. Talking about oneself can be hard, because the issues being explored may stir up painful emotions, including shame and the fear of being rejected by the therapist (Lilliengren and Werbart 2005). Being a client is not a matter of just taking what the therapist offers, but involves working hard to select and adapt therapist interpretations and interventions to make them fit one's own situation (Dundas et al. 2009). Making the most of the experience of therapy also requires being active between sessions, applying what has been learned in the therapy room (Manthei 2007). A further form of client activity involves the search for evidence that therapy is making a difference (Toto-Moriarty 2013). The process of change typically involves some degree of meaning-making, as the person learns to 'normalise' and make sense of adversities in their life (Grossman et al. 2006). For some clients, the accomplishment of some degree of meaningful understanding may function as a catalyst that then makes it possible to begin to engage with behaviour change initiatives. At the same time as being in therapy, the person may well be continuing to pursue external or adjunctive life-enhancing activities, such as reading, music, yoga, and spending time in nature. Beyond all this, clients may need to respond to how others in their lives are reacting to the changes that are occurring (or not occurring) as a consequence of being in therapy.

Managing the relationship with the therapist can be hard work. Therapists make mistakes – they can say the wrong thing, forget important information about the client, or pursue unhelpful strategies (Richards and Bedi 2015). Such moments can be extremely difficult for clients to handle, particularly if they feel angry (Dollarhide et al. 2012). It can feel very risky to directly challenge one's therapist, since most people feel a sense of gratitude and deference towards their therapist (Rennie 1994a). The process of repairing the connection with the therapist can take time and effort (Haskayne et al. 2014), and depends on the willingness of the therapist to acknowledge their error (Rhodes et al. 1994).

The actual process of change can be extremely hard. A person who enters therapy is likely to be struggling to cope with a problem or issue that may have dogged them for many years, and has eluded their own best efforts to address. Even if the client experiences a moment of epiphany or insight, this shift in attitude or understanding is likely to require a considerable commitment if it is to lead to a meaningful change in the actual everyday life of the client. Similarly, new skills acquired in therapy, such as how to say no, or how to control anger, need to be practised in real-life situations. Clients interviewed by Perren et al. (2009) and Răbu et al. (2013b) described the process of change as cleaning out all the cupboards in their personal space or 'sorting out the mess in the drawers', and deciding what to keep and what to throw away. What they are saying, here, is that change takes time, and involves a whole series of micro-decisions and actions. People who gain the most from therapy may often say, at the end, that they were surprised by what came out of therapy, in the sense that it took them to places in their own life that they had not expected to go, and given them new skills that they had not realised they lacked (Millar 2002; Westra et al. 2010).



### Case study 1.1: Beyond silence – reflections on a life as a therapy client

Linda Gask is a leading British psychiatrist and psychotherapist who has made major contributions to the development of psychotherapy research, the provision of therapy services in underprivileged communities, and the use of psychotherapeutically informed interpersonal skills in primary care physicians. In 2015 she published an autobiographical account of her lifetime struggle with depression, including her use of psychodynamic psychotherapy, CBT, and antidepressant medication (Gask 2015). This book conveys crucial aspects of the experience of being a client in therapy.

From the point of view of the client, the meaning of an episode of therapy requires placing it in the context of a life as a whole – it is not possible to appreciate how and why a particular therapeutic experience has been helpful (or not) without seeing how it relates to the history of what has gone before. Similarly, a label such as ‘depression’ (the main problem with which the author struggled throughout her life) is only an approximation, a general term that indicates a broad category of difficulty. Each person experiences their own ‘depression’ and over time develops a more nuanced and fine-grained understanding of how specific life experiences have shaped current issues, and how they can be undone. This process may involve retrieving memories of both positive and negative events from childhood. A key step in recovery is to begin to move ‘beyond silence’ in the sense of being able to find words to talk about areas of life that could never be discussed in the family environment where one grew up. Another key step is to learn and apply new skills and strategies – thinking different thoughts, responding to people in different ways. Yet another step involves paying attention to how other people deal with the same problems. All of this depends on being able to have a relationship of trust, care, and perhaps also love, with a therapist. Some therapeutic insights may take years to surface. Finally, this process never ends. It is clear, in the story told by Linda Gask, that while she became able to understand, accept, and manage the effects of the adversities she faced early in her life, and channel them into a successful professional career, the job was never done – it was always a matter of being alert to possible triggers, and gradually learning how to take care of oneself more effectively. Although written by someone whose training gave her a standpoint that is different from that of most people who seek help from counselling and psychotherapy, it is nevertheless a book that captures some fundamental truths about both the possibilities and limitations of therapy.

## Ending therapy

From the point of view of the therapist, the end of therapy is when their work is done. In addition, in most circumstances it is not possible for therapists to learn about the fate of their clients once regular meetings have stopped. By contrast, the end of therapy is highly significant for the client, because it marks a transition between a period when they were able to make use of the support afforded by ongoing contact with someone who was on their side and was trying (whether successfully or otherwise) to help them to overcome their problems, and having now to rely on their own resources.

There is some evidence that clients and therapists tend to have different understandings about the reasons why a client has decided to finish therapy (Hunsley et al. 1999). For a person in therapy, awareness that it will end, and appreciation and curiosity around what this might mean, functions as a backdrop to everything that happens in therapy. There are several ways that clients try to get a handle on whether it is time to end, or what the ending might be like: discussing the issue with their therapist, using a vacation or other breaks from therapy as a rehearsal for ending, and



personally reflecting on their own readiness to end (Etherington and Bridges 2011; Răbu et al 2013a, 2013b). Sometimes, the existence of new relationships means that therapy becomes less relevant, significant or necessary (Roe et al. 2006).

Follow-up interviews with clients have found mixed feelings about the ending of therapy (Knox et al. 2011; Olivera et al. 2013; Răbu and Haavind 2018; Roe et al. 2006). When therapy has gone well, there can be a sense of independence, of moving on with life from a better position, carrying forward the gains of therapy. There can also be a sense of loss of a meaningful relationship, and perhaps also regret at lost opportunities. Some people report anxiety around their capacity to manage on their own, or resentment at the way that therapy has ended (for example, if they wanted more time). There can be a sense of relief that something that was hard has come to a close. Each individual who finishes therapy will experience their own personal combination of these reactions.

There are different types of ending. From a therapist perspective, the intention or ideal scenario is that endings are agreed with the client, either in the form of an understanding from the start that therapy will be limited to a certain number of sessions, or that the decision to end will be discussed and negotiated as part of the work of therapy itself. From a client perspective, the situation is quite different. Regardless of how the therapist understands the process of ending, as many as half of clients just stop attending, without giving any reason. There is another, smaller set of clients who believe that their therapist has pushed them out – although they may wish to continue, their therapist has engineered an ending (Răbu and Haavind 2018). There has been limited research on what are defined in the literature as ‘unplanned’ endings (i.e. not planned by the therapist). Clearly, people who unilaterally just stop attending therapy are likely to be difficult to contact, or may not be willing to be interviewed. What is known seems to suggest that people who quit therapy tend to do so because they are unhappy with the service they have received (Chiesa et al. 2000; Marshall et al. 2016). In some instances, therapy ends because the person reaches the conclusion that it has been harmful for them (Bowie et al. 2016). However, there are also some people who appear to stop attending therapy because they have benefitted from it, see no need to continue, and for whatever reason neglect to inform their therapist about their decision (Simon et al. 2012).

### Box 1.2: Are those germs in your pocket?

A detailed account of living with obsessive compulsive disorder (OCD), engaging in various types of therapeutic intervention, gradually building his own personal theory of the disorder, and arriving at some kind of resolution, is available in a paper written by Ragan Fox (2014). This piece of work is fairly unique in that the author vividly describes his lived experience of specific moments in his therapy journey, such as what it was like to hear inner voices arguing with each other, a first visit to a psychiatrist, being in a therapy group, and a therapeutic homework assignment of going to see a dentist. What comes across powerfully in this narrative is the extent to which the love and support of others (in this case, his mother) was a necessary aspect of recovery, and the way in which he arrived at a point of defining his battle against OCD as an all-consuming personal project in which he drew on all possible resources, both within the world of therapy and outside of it, including the act of writing a highly revealing article that would be published in a widely read professional journal.

## Evaluating therapy

The evaluation of therapy is a further area in which there is a difference in perspective between clients and therapists. The knowledge of therapy held by therapists is largely based on close attention to what happens during therapy sessions and whether the client improved in relation to categories

(e.g. symptoms of depression or anxiety, insight, self-esteem, behaviour change) that are considered important within their theoretical model. By contrast, clients tend to forget the detail of therapy sessions. After the ending, if they think about their therapy at all, it is from a retrospective standpoint – looking back and reflecting on what it meant and what was gained.

Broadly, people evaluate therapy in terms of whether it provided them with what they needed at the time (Kuhnlein 1999; Valkonen et al. 2011). One group of people view their difficulties as arising from problems in early childhood, and evaluate therapy in terms of the extent to which it enabled them to come to terms with these early events. A second group see themselves as generally enjoying positive psychological and emotional functioning, and seek therapy in response to a temporary inability to cope with certain stressful events, such as a recent loss. These clients evaluate therapy in terms of the degree to which they have acquired specific knowledge and skills needed to deal with these events. A third group of clients understand their distress as arising from a lack of meaning in their lives, and evaluate outcome in relation to what they have learned around cultivating sources of meaning. Gibson and Cartwright (2013, 2014a) found that people looking back on their therapy told different types of story about their experience. Some people told stories of therapy having transformed their lives. Other narratives reflected a more pragmatic understanding of their therapy, as something that had supported them through a difficult phase in their life. Finally, there were people who were disappointed in their therapy, and felt they had not got what they needed.

A useful source of insight into the value of therapy comes from studies that have asked people not specifically about their therapy, but to talk more widely about how they had recovered from an issue such as depression, trauma, or loss. What people typically say in these interviews is that therapy was helpful for them, but only in the context of many other self-initiated activities that they were pursuing at the same time (e.g. Grossman et al. 2006; Wilson and Giddings 2010). What seems to be happening is that therapy functions, at least for some people, as a form of support while they engage in real-life activities (e.g. outdoor pursuits, spiritual practices, art-making) that have the potential to contribute to their learning and healing. Therapy also provides an arena for sifting through and reflecting on the value and meaning of these activities.

An important way that therapy may have an enduring influence is to give the person access to an internalised image, voice, or memory of their therapist. Even many years after completing therapy, people report that they vividly recall specific things that their therapist said to them, or are even able to hold imaginary private conversations with their former therapist, for instance, in moments of stress (Knox et al. 1999; Mosher and Stiles 2009; Myers and White 2010). Many people are also able to identify specific skills and insights that they acquired in therapy, and continue to apply in everyday life.

Disappointment is a recurring theme that emerges in studies that invite former clients to look back on their experience of therapy (Gibson and Cartwright 2014a; Morris 2005; Nilsson et al. 2007; von Below and Werbart 2012). Sometimes disappointment is expressed in the context of a therapy that was, in many respects, valuable. This type of disappointment seems to refer to a feeling that although therapy was good, there was still something missing. For example, the therapist may have been very helpful in respect of facilitating cognitive understanding of issues, but not so good at enabling the person to express emotion. In other cases, there may be a more pervasive sense of disappointment, expressed in the view that the therapist did not understand them and was not sufficiently flexible, or that the therapy was not sufficiently intense or focused. Beyond disappointment may be a belief that therapy has had negative consequences (Bates 2006; Bowie et al. 2016; Nachmani and Somer 2007) because the therapist acted in ways that were insensitive or exploitative.

An underlying metaphor that emerges in many conversations where people evaluate their therapy, is that of the 'journey'. People enter therapy because they see themselves as 'stuck' or 'going nowhere', and regard their therapy as having been successful if it has contributed to 'moving on' or 'getting life back on track'. Useful therapy also provides the person with tools or strategies that they are able to use to ease their progress on the journey. Being on a journey is a way of expressing a sense of agency or purpose, which represents another core theme in the way that people talk about successful therapy (Gibson and Cartwright 2014a). People who have benefitted from therapy do not

describe it as an 'intervention' that was administered *to* them, but as an activity or experience that they purposefully and intentionally used in order to accomplish their own personal goals.

The meaning and personal impact of therapy continues beyond the point when regular meetings with a therapist have ended. About 50–60 per cent of clients report meaningful benefit at the end of therapy, compared with how they were at the start. Some people then continue on a trajectory of improvement, while others describe their therapy as incomplete or unhelpful, and gradually slip back into a troubled state (Ekroll and Rønnestad 2018).

## Coming back for more

Many people who have had therapy come back for more therapy at a later point in their lives. This issue has not been extensively investigated in research on therapy. For the most part, therapy research has looked at specific episodes of therapy, rather than taking a life-span approach that tracks a person through different encounters with therapy at different stages in their life. In research that asks clients about what therapy has meant for them, many people answer by comparing the meaning or impact of different therapy episodes. For example, one episode of therapy may have been highly personally significant because it was the time when they finally decided to stop being afraid of intimacy in relationships, while another episode may have been fairly unhelpful because all they got from it was that they learned that a particular therapy approach was not right for them, while a third episode may have been useful in the sense of maintaining their equilibrium during a period of high work stress (McKenna and Todd 1997). Therapists sometimes worry about clients who become dependent on therapy as a means of avoiding the challenges of messy real-life relationships, or who move from one failed therapy to another as a way of maintaining a sense of how crazy they are, and/or how useless mental health professionals are. Undoubtedly such things happen. But, for many people, therapy becomes a rational and meaningful way of coping with a stressful world, and a means of renewing their creativity and sense of enchantment with the world.

## Conclusions

The picture that emerges from research studies and biographical accounts that seek to capture the experience of being in therapy is that of a process in which there is a great deal of uncertainty, where the person needs to draw heavily on their own courage and resourcefulness in order to make it work for them. In this process, the therapist may have many tangible things to offer – ways of understanding, strategies for coping, techniques for managing emotions, relationships and distorted ways of thinking. What is just as important is that the therapist functions as a source of support and caring as the person tries out things for themselves. In some cases, the therapist becomes such a significant person in the life of the client that it makes it possible for them to see that there are ways of relating to another person that are quite different from anything that they may have come across before.



### Topics for reflection and discussion

- 1 Carry out a Google search around the topic of 'personal experience of therapy'. In what ways do these accounts add to the understanding of being a client that is offered in the present chapter? To what extent is it possible to identify different themes in client experience pieces written for different audiences?



- 2 To what extent, and in what ways, does the description of the therapy journey in this chapter correspond to your own personal experience, or the experience of people you know who have made use of therapy?
- 3 The literature on the client experience of therapy can be criticised for not paying sufficient attention to what therapy is like for people whose identities include membership of oppressed, stigmatised, and marginalised groups. What would you expect to be the main differences in therapy experience that might emerge if such voices were given greater prominence?
- 4 As a client or therapist, what do you view as the main practical implications of the evidence that has been accumulated around the client experience of therapy? How can these insights be used to improve the effectiveness and accessibility of therapy services?

## Suggested further reading

The references cited in this chapter comprise fascinating and informative studies or personal accounts of client experience. Each of them repays close reading – this kind of qualitative research contains richness and depth that can never be properly conveyed in brief summaries that only highlight ‘headline’ themes. Levitt et al. (2016) provide a comprehensive summary and review of this literature, and their list of 109 studies includes many possibilities for further reading. It is important, when reading client accounts of the experience of counselling and psychotherapy, that these are not literal descriptions, but are narratives that tell a story in a particular way. An interesting analysis of how to make sense of contrasting narrative styles and purposes in client stories about therapy can be found in Adler (2013). Finally, video recordings and podcasts of actual therapy are becoming increasingly available on social media. This kind of material tends to come and go, so it is necessary just to do a search and see what can be found.

# Chapter

# 2

## What it's like to be a therapist

<b>Introduction</b>	<b>13</b>
<b>What therapy tries to achieve</b>	<b>14</b>
<b>What therapists do</b>	<b>15</b>
General principles	15
<i>A place to talk</i>	15
<i>A therapeutic space</i>	17
<i>A way of being</i>	17
<i>A supportive relationship</i>	18
<i>Making sense of complex problems</i>	19
<i>Staying safe</i>	19
<b>Specific therapist practices</b>	<b>20</b>
Micro-skills	20
Interventions and techniques	22
<b>The experience of being a therapist</b>	<b>24</b>
<b>Conclusions</b>	<b>25</b>
<b>Topics for reflection and discussion</b>	<b>26</b>
<b>Suggested further reading</b>	<b>26</b>

### Introduction

Therapy offers a highly flexible form of help. Most people who enter therapy have multiple problems and issues. These issues have developed over time, and tend to occur in a unique or idiosyncratic pattern in each case. People also have different levels and types of support and resources, and may be at different stages in relation to the severity of their problem and their readiness to change. There are some people who have clear-cut difficulties that may respond well to instructions and guidance, for example through a self-help book or website. However, many people benefit from having the assistance and support of a therapist to unpick the different strands of their difficulties, and to figure out how the available models and techniques can be adapted to their client's own individual circumstances.

Therapists make a difference. If it goes well, the experience of being a client in therapy involves meeting and spending time with someone who becomes a memorable figure in the gallery of those who have had a significant impact on their life.

This chapter begins by briefly considering the question of what therapists are charged with delivering – what is therapy trying to achieve? The focus then turns to looking at *how* therapists facilitate the accomplishment of these outcomes – skills and interventions. The final section considers the experience of being a therapist, in terms of its impact on one's life.

## What therapy tries to achieve

The potential outcomes of therapy can be understood as falling into three broad categories:

- 1 *Resolution* of the original problem in living. Resolution can include achieving an understanding or perspective on the problem, arriving at a personal acceptance of the problem or dilemma, and taking action to change the situation in which the problem arose.
- 2 *Learning*. Therapy may enable the person to acquire new understandings, skills, and strategies that make them better able to handle similar problems in future.
- 3 *Social involvement*. Therapy can stimulate the energy and capacity of the person as someone who can contribute to the well-being of others, as an active member of society.

The underlying factor in all three of these broad themes or categories is that of being 'stuck' or demoralised (Frank and Frank 1993) and then finding ways to 'move on' in one's life. Within these overarching themes, there exists a wide array of more specific personal gains that may arise from the experience of therapy:

- *Insight*. The acquisition of an understanding of the origins and development of emotional and interpersonal difficulties, how they are maintained, and what triggers them, leading to an increased capacity to take rational control over feelings and actions, and manage situations.
- *Relating with others*. Becoming better able to form and maintain meaningful and satisfying relationships with other people – for example, within the family or workplace.
- *Reducing or eliminating symptoms*, such as depression, suicidality, fear/anxiety, obsessions and compulsions, trauma reactions, substance misuse, disordered eating behaviour, grief, sleep, sexuality, somatic problems, and stress.
- *Finding meaning in life*. Discovering or rediscovering reasons to live, a sense of mattering, moving on from loss, gaining purpose. Meaning-making can refer to the process of making sense of a specific event, or to the search for meaning in one's life as a whole.
- *Self-awareness*. Becoming more aware of thoughts and feelings that had been blocked off or denied, or developing a more accurate sense of how self is perceived by others.
- *Self-acceptance*. The development of a positive attitude towards self, marked by an ability to acknowledge areas of experience that had been the subject of self-criticism and rejection.
- *Self-actualisation or individuation*. Moving in the direction of fulfilling potential (e.g. in a creative field, or within a career) or achieving an integration of previously conflicting parts of self.
- *Enlightenment*. Moving towards, or achieving, a higher state of spiritual awakening.
- *Problem-solving*. Finding a solution to a specific problem that the client had not been able to resolve alone. Acquiring a general competence in problem-solving.
- *Psychological education*. Acquiring ideas and techniques with which to understand and manage situations and behaviours.
- *Understanding therapy*. Learning about how therapy might be useful, or which aspects might be useful, in relation to future personal crises. Learning about how therapy might help other people.

- *Acquisition of social skills.* Learning and mastering social and interpersonal skills such as maintenance of eye contact, turn-taking in conversations, assertiveness, or anger control.
- *Cognitive change.* The modification or replacement of irrational beliefs or maladaptive thought patterns associated with self-destructive behaviour.
- *Behaviour change.* The modification or replacement of maladaptive or self-destructive patterns of behaviour.
- *Systemic change.* Introducing change into the way in which social systems (e.g. families, workplace) operate.
- *Empowerment.* Working on skills, awareness, and knowledge that will enable the client to take control of their own life.
- *Restitution.* Helping the client to make amends for previous destructive behaviour.
- *Generativity and social action.* Inspiring in the person a desire and capacity to care for others and pass on knowledge (generativity) and to contribute to the collective good through political engagement and community work.
- *Addressing moral injury.* Enabling a person to acknowledge, accept, and move on from the experience of having done something that was morally wrong.

Even though this is an extensive list, anyone who has been involved in therapy as a client or practitioner will be able to identify further items that could be added to it. The key point here is that a therapist needs to be flexible enough to make it possible for the client to use the therapeutic relationship as an arena for exploring whatever dimension of life is most relevant to their well-being at that point in time. A good therapist is not a technician who applies a standard set of procedures to all clients, but is someone who has an appreciation of multiple ways in which therapy can be helpful for people.

## What therapists do

A good way to learn about therapy is to watch videos of therapists at work, or to read transcripts of therapy sessions. Many therapy videos are available for free on the internet, for example on YouTube. In addition, collections of therapy videos have been published by the American Psychological Association, Sage Publishing, the Alexander Street Press, and other organisations. What you see in a video can be understood at different levels. At one level, you will see something like a dance going on – two (or more) people doing something together that involves subtle adjustment to the actions and words of each other. This is easier to detect by turning the sound off or increasing the playback speed. But something else is happening, which is harder to pin down. Together, the therapist and client(s) are creating a particular kind of event or situation that seems somehow different from other types of meeting between people. Finally, by watching the video often enough, it becomes possible to pin down precisely what the therapist is up to, in terms of specific ways of responding, and setting up sequences of interaction, that have a distinctively therapeutic purpose.

## General principles

As will become apparent in Part 2 of this book, there exist many different traditions and styles of therapy. Despite this diversity, it is possible to identify a set of general therapeutic principles that underpin all forms of therapy, and mark out therapy as different from other types of interpersonal encounter. These principles reflect a broad sense, shared by all therapists, of what they are trying to achieve.

### *A place to talk*

‘Just talking’ is the basic intervention offered in therapy, and the cement that holds all other interventions together. Talking represents a fundamental human attribute that is linked to the capacity

of human groups to offer mutual support and to act together for the common good. In addition, meaning-making, problem-solving, connecting with others, and the transmission of a shared culture, are all made possible through language.

There are many crucial processes of learning, change, and personal development that may be facilitated by talking about a problem. Simply telling the story of one's troubles can be helpful in itself. Quite often, a person may have never shared their story, or significant aspects of the story, before having the opportunity to do so with a therapist. The telling of the story creates a situation in which the person is able to reflect on what has happened, through allowing distance between the account of the experience and the person's capacity for reflection. The process of reflection can result in the development of understanding, which can allow action planning. In many instances, a story has not been previously recounted because the person does not wish to experience difficult emotions that might be triggered through the telling. The presence of a caring listener can give the person the courage to allow these emotions to be expressed, which can in turn lead to further understanding and closure. The expression of emotion also makes it easier for the listener to appreciate the true meaning of the experience that is being described. Finally, telling one's story to a therapist may make it easier, at a later stage, to find suitable means of telling the story to others in everyday situations.

Beyond these ways in which 'just talking' can be helpful, there are other therapeutic possibilities that arise within client–therapist conversation. Good therapists are sensitive to many aspects of language. The way that a person talks about their life, for example the choice of words, can be regarded as a construction. It is as though the person is creating or conveying a version of reality that reflects not only their own personal experience of life, but also their position in relation to gender, social class, and other factors.

The metaphors that punctuate a person's talk convey important information about the meaning of experiences in their life. For example, 'my relationship with my spouse is not good' may be an important thing for a client to say. However, 'my relationship with my spouse is like a constant battle' allows the listener to get closer to the experience of the speaker, by drawing on the imagery and meaning of what it might be like to be in a war. Speakers tend to generate a large number of metaphors within a conversation. We tend not to be consciously aware of metaphor – listening to or reading a recording or transcript of a therapy session, and listening for metaphors, is a simple way of demonstrating this phenomenon.

A further conversational process that can have therapeutic effects is the use of humour. Humour can contribute to the development of a therapeutic relationship through the occurrence of moments of affiliation and connection, and a shared set of humour reference-points or running jokes. Therapist feedback or challenge can be more effective when offered in a format that invites the client to see the absurdity of their choices and behaviour. Laughter can function as a form of emotional release. In addition, the logic of the joke involves the awareness of an unexpected or creative perspective on a situation, which can help the person to gain reflective distance on an issue.

Many other aspects of conversation may also be relevant to the process of therapy, such as the degree to which turn-taking is smooth or awkward, and the significance of changes of topic (e.g. the person stops talking about their anxieties and panic attacks, and for some reason begins to talk about a movie they saw on the TV). The concept of *dialogue* captures the deepest possibility for conversation to bring people together. In much conversation, people do not fully listen to each other, talk past each other, are defensive, or strive to make points and put the other person down. By contrast, dialogue refers to moments in a conversation when each participant is both open to self (their authentic beliefs and feelings) and open to the uniqueness of the other. Many therapists regard dialogue as having a vital healing potential in itself, because it allows the person to be part of a shared or collective reality beyond the self – an experience that leads to an expansion of the horizon of understanding of both persons.

Effective therapists are often people who appreciate language, and are interested in literature, poetry, song, and drama as sources of learning and inspiration in relation to the possibilities of

language. There exist a wide range of therapist skills and micro-interventions that involve informed and sensitive use of language to shape and manage the flow of conversation in a therapy session.

### *A therapeutic space*

One of the most important things that a therapist does is to offer and create a special kind of space, separate from everyday life, that the person can use as a sanctuary and as a place within which they can reflect on their life as a whole and on specific difficulties that they may be experiencing.

Most therapy takes place in the context of a one-hour meeting in an office on a weekly basis. This arrangement opens up a space in the weekly routine of the client, within which conversation can take place that is different from that which occurs in the person's everyday life. Therapy conversations are characterised by the focused attention of the therapist on the client, confidentiality and privacy, and permission to talk about potentially painful and embarrassing content. The therapy hour helps to give structure to the week. It can become something to look forward to: an outlet for talking about stressful situations. It can become an experience that is recalled between sessions, as a source of inspiration or hope, or in terms of continuing to think about issues that were discussed. The therapist themselves can become someone who the person may look forward to seeing again. In some instances, the décor and ambience of the therapy room, or therapy centre, can make it a special place that is pleasurable to visit. There may be therapy rituals, for example around starting or finishing a session, that may become meaningful for the person. Therapy sessions can be viewed as offering a particular kind of space in the everyday life of the person, that stands in contrast to the routine that surrounds it.

It is the responsibility of the therapist to build and maintain this therapeutic space, for example by ensuring that they are on time, the room is fit for purpose, and that no interruptions will occur. It is also the responsibility of the therapist to defend the space against external threat, such as noise in the corridor, or the clinic management changing the time slot. The establishment of such a space can have a profound effect on a person who is seeking help for problems in living.

### *A way of being*

Therapists tend to exhibit a distinctive way of being, that is both similar to and different from the interpersonal style of other helping professionals or health workers. An important aspect of this is acceptance of the client as a person, expressed through warmth and also in the form of a non-judgemental attitude to whatever the person has to say. Acceptance is also conveyed through valuing the person, belief in the capabilities and resourcefulness of the person, and a sense of hopefulness that things can get better. Therapists also tend to talk in a particular way, for instance by reflecting back key phrases, using pauses that allow space for reflection or opportunity for more to be said, lack of direct questions, tentativeness, talking quite slowly, and use of a soft voice. Perhaps the single most important characteristic of a therapist way of being is resolute listening. A therapist listens very closely to the client, and focuses in particular on the client's personal experience and inner world. Although such a strategy may suggest intimacy, it is balanced by a sense of distance. For example, unlike other intimate relationships, a therapist is unlikely to share much about their own self or personal experience. These aspects of a therapist way of being may be experienced by a client as unusual or strange, because they may not previously have encountered anyone who acted in this manner. This sense of the therapist as being somewhat different from an ordinary person may be reinforced as therapy proceeds, and the therapist expresses ways of understanding and seeing situations that differ from the client's own attitudes and values.

A crucial aspect of a therapist way of being is a capacity to tailor one's reactions to the moment-by-moment needs or mode of expression of the client. This characteristic has been described as therapist *responsiveness* (Honos-Webb and Stiles 2002; Kramer and Stiles 2015; Stiles 2009; Stiles et al. 1998). What this means is that a good therapist is never merely applying a model or theory of therapy, but is adapting and adjusting it in accordance with what seems most helpful for the client at any point in time.



Two further facets of a therapist way of being are courage and persistence. Many clients want or need to talk about issues that are uncomfortable to hear about – for instance, times when they felt terrible fear or utter despair. Clients may also express strong emotions, sometimes directed towards the therapist. In everyday life contexts, these are situations that a person might seek to mitigate, limit, or avoid. A therapist, by contrast, needs to be someone who has the courage to tolerate such moments. Similarly, it is the job of the therapist to be persistent in returning to such themes, or to be willing to reiterate personal truths that the client is trying to avoid.

In terms of facilitating learning and change, the therapist way of being has a number of possible effects. It can function to elicit particular types of response in the client. For example, it creates a situation that highlights the client's personal experience and feelings, and encourages self-exploration. With some clients, the slower pace of the therapist's way of talking may lead them to slow down their own rate of talking, which may have the effect of opening up moments of reflection. The therapist may function as a model of a deliberate, thoughtful, and respectful way of interacting with others. Taking these elements as a whole, what may happen for some clients is that meeting someone who does not quite fit into any of the categories of personal interaction with which they are familiar, allows them to try out new ways of being for themselves. This process has been described in psychoanalysis as a 'corrective emotional experience': the person may have never had the experience of interactions where their feelings, emotions, and inner world were of interest to the other, and therapy allows a chance to learn what this is like, and try it on for size.

### *A supportive relationship*

A client and therapist will usually meet more than once. They get to know each other, and have a personal and emotional investment in each other. This means that there is a relationship between the client and the therapist. One of the crucial aspects of being a therapist, therefore, is a willingness to enter into a relationship with the client. This may seem obvious, but it is not. Although the therapist–client relationship is a professional relationship, it differs from other professional relationships in that it necessarily has a significant personal dimension. The client comes to therapy to explore personal issues, and the therapist is inevitably touched and affected, personally, by what is discussed. In addition, most of the time, a therapist is the sole – or main – practitioner who interacts with a client. In other professional settings, such as a hospital or school, a client may be looked after by a team of practitioners, and as a result there may not be a particularly close or continuous connection with any specific helper. Some psychiatric patients may see their psychiatrist briefly once each month (possibly less often). The relationship between a counsellor/psychotherapist and a therapy client is therefore quite different, in intensity, from these other types of professional relationship.

By being willing to forge a relationship with a client, a therapist is implicitly stating a willingness to make that relationship work. This commitment can turn out to be a central aspect of the way that therapy is helpful for a client. Many people who seek therapy are, at that point in their lives, not in a position of having good relationships with other people. For example, people who are depressed may be socially isolated and believe that no one could ever like or accept them, people who are anxious may be fearful, and so on. By making the relationship work, a therapist may well be creating the conditions for other relationships in the client's world to work as well.

The subject matter and goals of therapy mean that it is inevitable that the client and therapist will encounter relationship challenges. Early on, the client needs to decide whether the therapist is someone they can trust, and whether the care and interest exhibited by the therapist is real and genuine, or just a professional façade. As therapy unfolds, there will be moments when the therapist does not understand the client, or says or does something that is unhelpful or even hurtful. These ruptures can lead to reflection and learning around what is involved in repairing a relationship, or in forgiving someone, or in knowing the limits of one's responsibility. The end of therapy opens up issues around loss, saying goodbye, and how to deal with disappointment. Throughout therapy, there is an ongoing question of collaboration: how can two people work effectively together?

At the heart of therapy is the experience of asking for help from another human being. Inevitably, whether it is explicitly discussed in therapy sessions or not, a client compares the help relationship they have with their therapist to other help relationships that they have known: mum and dad, other family members, spouse/partner, friends, minister or priest, other professional helpers. What happens in the therapy help-relationship will often have the effect of recalibrating these other, real-world relationships.

Some approaches to therapy, such as psychodynamic and humanistic, place a strong emphasis on the client–therapist relationship as a vehicle for learning. Other therapy traditions, such as CBT and systemic/family, devote more attention to other types of change process, and are less interested in what is happening in the client–therapist relationship. However, these positions are merely a matter of degree: the client–therapist relationship is always important.

### *Making sense of complex problems*

An essential, but somewhat unacknowledged, facet of the activity of offering therapy consists of a capacity to make sense of the client's problems, and convey this perspective to the client in a manner that allows them to use it to manage the difficulties with which they are struggling. At the point of entering therapy, the person may have run out of options, in terms of how to get a handle on what is bothering them. In some instances, the person may experience the world as a frightening and confusing place, which makes little sense to them. For example, someone who has undergone a traumatic event may subsequently experience sudden flashbacks or moments of terror that do not appear to have any logical connection to anything else that is happening in their life at that moment. For such individuals, an explanation of the nature and process of reactions to trauma can fairly quickly demystify the experiences they are having, allay the fear of going mad, and open up possible routes towards ways of coping.

Through their training and ongoing study, therapists have access to a wide repertoire of ways of making sense of emotions, ways of thinking, relationships, and behaviour. A therapist will be aware of everyday common-sense ways of making sense of problems that are available to all members of the cultural community within which they live. It is likely that someone who has become a therapist has developed a special interest in this stock of common-sense knowledge, and has an appreciation of its strengths and limitations in respect of the matter in hand. Therapists have close familiarity with concepts and models from psychology and therapy theories, and will almost certainly have gone through a process, in training and personal therapy, of using these ideas to make sense of their own life. Finally, most therapists have a working knowledge of psychiatric/medical ideas around the main diagnostic categories such as depression, anxiety, and psychosis.

When asked about their goals for therapy, many clients state that being able to make more sense of current problems is one of their main hopes. When asked, at the end of therapy, what was helpful for them, many clients talk about the value of having gained a more coherent 'perspective' on their lives. These observations support the notion that client understanding and conceptualisation of problems is a core competency for therapists.

### *Staying safe*

Being a therapist involves working within a professional framework that stipulates ethical standards of good practice. Beyond these professional requirements, an underlying implication of the therapeutic principles described in the preceding sections is that fulfilling these principles requires a genuine personal commitment to place the client first. A key aspect of this is looking after the safety of the client. Therapists work hard to avoid doing harm to clients by ensuring that they are competent in the therapy techniques that they use, and that they monitor their competence by getting feedback from clients on the results of these outcomes, consult with colleagues and clinical supervisors, and regularly refresh and update their skills and knowledge base. The process of therapy can involve a client being temporarily in a state of mind from which they might choose to do harm to self or others. In these situations, a therapist is a representative of the



best interests of the client, and does all they can to engage the client in dialogue around how to maintain their safety and the safety of others, while acknowledging the underlying rage, hurt, or despair that lies behind these impulses.

## Specific therapist practices

General therapy principles, such as creating a space to talk, or conceptualising, refer to the underlying 'deep structure' of therapy. These principles represent broad categories or themes that can be expressed in many different ways. In order to achieve a closer appreciation of what therapists do, the following sections take a closer look at concrete aspects of therapy practice that are more directly observable in video or audio recordings of therapy.

A strategy used in some of the earliest research into what therapists do was to analyse therapist behaviour in terms of verbal response modes, such as interpreting, information-giving, advising, questioning, and confirming (Hill 1989; Stiles et al. 1992). Although looking at such 'molecular' items of therapist behaviour can provide a valuable means of categorising aspects of therapeutic process, it provides limited insight into the meaning or intention of what the therapist is trying to achieve. The following discussion, therefore, focuses on two ways of analysing therapy practice that similarly look at the detail of what is actually happening, but have the potential to reflect the meaningfulness or purposefulness of what is being observed: micro-skills and interventions.

### Micro-skills

What therapists do can be broken down into a wide range of component micro-skills, each of which comprises a brief sequence of therapist–client interaction. These skills represent the basic building-blocks of therapist competence. When watching a video of a therapy session, it is apparent that points at which therapy appears to flow along seamlessly are associated (on closer scrutiny) with expert, timely, and sensitive use of appropriate skills. By contrast, moments when therapy seems to stall are associated with awkward or inappropriate skill usage.

*Listening.* When a therapist listens, they pay attention not only to the content or topic that the client is talking about, but also to the feeling-state that is being conveyed, the way the person is talking, and any implicit meaning that may lie behind the words. The act of listening includes the physical process of attending, such as leaning forward, making fine movements in synchrony with the speaker, and emitting murmurs of minimal encouragers that indicate continued interest in what is being said. Listening also operates at the level of the internal awareness of the listener. As the person speaks, the listener may experience a number of competing cognitive processes, such as staying with what is being said, interpreting the meaning of what is being said, consciousness of personal memories triggered by the speaker's words, and formulating a verbal response to the speaker. The listener may also be aware of their own inner feeling states elicited by the topic, and may be conscious of their role as a helper/therapist.

*Checking out, clarifying, reflecting, and restating.* Part of the skill of being a therapist is to clarify with the client that what has been understood is accurate. This skill allows the therapist to determine whether they have a valid appreciation of what the person is trying to communicate, and also reassure the speaker that their interlocutor is following them. An effective clarification or reflection needs to be well-timed, to avoid diverting the person from the track they have been following. It needs to be clear and succinct (rather than confusing and rambling), and also to capture the gist or true meaning of what the person has been talking about. Typically, such statements are offered in a tentative fashion, that leaves spaces for the client to complete the statement or to correct or refine the therapist's summary statement. The tone of voice with which a reflection is made may also be

important. For example, if a person is talking about painful experiences, it may be helpful for the therapist to use a soft, soothing voice. In other situations, it may be more facilitative to match the client's voice quality.

*Silence.* A crucial aspect of therapy talk is that, unlike ordinary real-life conversations, a therapist tends to be more willing to allow silences to develop. A period of silence may allow the person to stay with a feeling, or to continue to internally process some aspect of an issue that is being explored. Brief silences may also convey a sense that the person is in control of the situation. On the other hand, periods of silence may be uncomfortable for the person, or may give the impression that the therapist is rude or uncaring. Handling silence is therefore a delicate skill, which requires sensitivity to the internal feeling state of the client, and the flow of conversation at any particular moment.

*Self-disclosure.* A further important difference between therapy and real-life conversation lies in the use of self-disclosure. For example, when two friends are talking, they typically take turns to tell stories about what they have been doing. In contrast, in therapy the client tells stories about their life but the therapist very rarely does. On the other hand, there may be times when it can be helpful for a therapist to share some aspect of their own life, or their experience of a topic being discussed by a client. Therapist self-disclosure is a skill that requires timing and a capacity to formulate what is being said in a way that is helpful for the client. As with other counselling skills, it also requires an ability to observe the effect on the client, following such a response by the therapist.

*Challenging.* The act of challenging or confronting a client, or offering feedback, can be difficult for therapists. Therapists tend to adopt a supportive and enabling role in relation to clients, featuring high levels of supportive and enabling responses. There may be a fear, therefore, that challenging the client around their attitudes or behaviour could put the therapy relationship at risk. It is also possible that challenge may represent an attempt to impose the therapist's values, or that the client may not be ready to take an alternative perspective on board. At the same time, it is clear that many clients want their therapist to challenge them, or at least say that this is what they want, on the grounds that it can be valuable to gain an independent unbiased opinion on how they are handling life issues. Some of the key elements of the skill of using challenge in therapy may include timing, specificity, and formulating the challenge so that it takes the form of self-confrontation (i.e. pointing out the discrepancy between competing positions taken by the client at different times).

The above are just some of the counselling skills that are required in order to function as a therapist. Other important skills include advice/information-giving, metacommunication, using different types of questioning, appropriate non-verbal behaviour, and reframing (Hill et al. 2014; McLeod and McLeod 2011). These skills are highly significant aspects of effective therapy, in several ways, and a serious deficit in any of these skills may fatally undermine the process of therapy. For example, if a client does not believe that their therapist is truly listening to them, they may emotionally withdraw or quit. In addition, more complex interventions, described in the following section, rely on the use of basic skills and can be viewed as ways of combining basic counselling skills to achieve a particular purpose.

One of the tests of an effective therapist is that they are not only able to master skills that are counter-intuitive when compared to how they might interact in ordinary everyday situations (e.g. silence rather than filling in the gaps in a conversation), but that they need to possess sufficient confidence and competence in the use of these skills not to revert to conventional patterns (e.g. arguing back in response to an angry client) at crucial moments. Anderson et al. (2009) evaluated the ability of therapists to handle particularly difficult client scenarios, such as a client who is confrontational and angry ('you can't help me'), passive, silent, and withdrawn ('I don't know what to talk about'), or

controlling and blaming ('you are not good enough for me'). What they found was that more effective therapists (with real-life clients) were those who exhibited higher interpersonal skills under pressure, as assessed in their lab experiments. The importance of mastery of 'skills-under-pressure' (Anderson et al. 2009) is particularly important given the fact that one of the main purposes of using counselling skills is to create a conversational context in which the client becomes able to talk about, reflect on, and explore aspects of their life that are emotionally painful, shameful, or embarrassing.

## Interventions and techniques

A further way of understanding what therapists do is to consider longer sequences of client–therapist interaction that display the application of multiple skills to accomplish a particular therapeutic effect. In order to gain a better understanding of this aspect of therapy, various research teams have constructed detailed checklists, observation guides, rating scales, and questionnaires based on lists of therapist techniques and interventions. Such instruments include the Therapeutic Procedures Inventory (McNeilly and Howard 1991), Comprehensive Therapeutic Interventions Rating Scale (Trijsburg et al. 2004), Multitheoretical List of Therapeutic Interventions (McCarthy and Barber 2009), Therapist Techniques Survey Questionnaire (Thoma and Cecero 2009), Psychotherapy Process Q-Sort (Jones 2000), and Practice Study Outpatient Psychotherapy-Switzerland Scale (PAP-S 100; Tschuschke et al. 2015). These instruments provide a comprehensive picture of what therapists do in sessions. It is of interest that, even though the authors of these scales were working independently, they have each arrived at lists that overlap to a substantial degree. A useful way to understand how therapy works in practice is to read through these lists. For example, in the questionnaire designed by Thoma and Cecero (2009), which was completed by a large number of therapists using different models of therapy with different client groups, it was found that virtually all of the therapists in the survey described themselves as using the following techniques and interventions on a regular basis:

- trying to understand the world from the client's point of view;
- challenging maladaptive or distorted beliefs;
- planning and encouraging alternative behaviours for problem behaviours;
- assisting the patient to work through or apply insights to a range of life situations;
- training the client to notice how thoughts, assumptions, or beliefs cause different emotional responses;
- calling attention to here-and-now awareness;
- teaching clients to recognise and change their 'shoulds', 'oughts', and 'musts';
- scheduling or encouraging pleasurable activities;
- offering positive reframing to help a person change their narrative about a person or situation;
- facilitating the discovery of a sense of meaning and purpose;
- exploring early childhood experience;
- encouraging the client to examine their own role in the maladaptive family system;
- exploring and interpreting emotional problems in terms of problematic interpersonal relationships;
- giving the client feedback about their present-tense body language or manner of speech;
- exploring and interpreting role transitions as sources of distress.

The universality of these techniques is not just a matter of therapists believing that they do these things. Studies that have used trained observers to painstakingly analyse audio or video recordings of therapy sessions arrive at similar conclusions.

In addition to these generic or 'non-specific' techniques and interventions, there also exists a heterogeneous set of interventions that are either idiosyncratic or associated with a particular style or theory of therapy. Examples of theory-informed exercises include the use in CBT of the method of systematic desensitisation, 'two-chair' work in gestalt therapy, and experiential focusing in person-centred therapy. Examples of idiosyncratic interventions, passed on from one therapist to another informally or on training courses, or invented by individuals themselves, include using buttons or animal figures to represent members of a family, drawing a 'life-line', reflecting on the memories evoked by significant photographs, and guided fantasy. Several books are available that offer collections of widely used therapeutic activities and interventions (Burns 2010; Carrell 2001; Greenberg et al. 1993; Hall et al. 2006; Hecker and Deacon 2006; Hecker and Sori 2007; King 2001; Leahy 2003; Seiser and Wastell 2002; Sori and Hecker 2008; Timulak 2011; Yalom 2002). In some instances, therapy interventions may encompass homework assignments, which the client carries out between sessions. Examples of homework assignments are: keeping a diary or personal journal; spending time each day pursuing a therapeutically valuable activity such as listening to one's partner, meditating quietly, or exercising; doing research on one's family history; reading a self-help book or 'inspirational' novel; or watching a 'therapeutic' film.

The value of structured exercises varies a great deal, depending on the preferences of the particular client and counsellor involved. Some counsellors work effectively without ever using such 'props'; others find them invaluable. Some clients appreciate the structure provided by an exercise; others seem to find that it creates a distance between them and their counsellor, and prevents them from talking about what is really on their minds.

Working with client dreams provides a good example of how different therapeutic processes are interwoven within an intervention that may span several therapy sessions. A significant proportion of clients believe in the value of dream analysis, and expect some form of dreamwork to be part of the therapy 'menu'. Although the use of dreams in psychotherapy originated into the interpretive, psychoanalytic approach to dreamwork devised by Freud and Jung, many contemporary counsellors prefer to adopt a more collaborative style of working with dreams, such as the cognitive-experiential model developed by Hill (1996, 2004). This model describes three stages of the interpretation of a dream: exploration, insight, and action. The *exploration* stage begins by explaining the procedure to the client, then inviting them to recount the dream in the first person present tense, as if it was being experienced in the moment. The client is then asked to describe the overall feelings associated with the dream, before being invited to explore the meaning of between five and ten major images in the dream, in terms of associations and waking-life triggers. The therapist then summarises what has emerged during the exploration process. During the *insight* stage, the client is encouraged to share their own interpretation of the meaning of the dream, and to deepen that interpretation by considering the relevance of the dream to waking-life triggers and inner personality dynamics (for example, conflicts between parts of the self). Finally, in the *action* stage, the client is asked to change the dream, by imagining a different ending or sequel, and to identify behavioural changes that may be suggested by the dream interpretation.

This model of dreamwork brings together a wide range of therapeutic skills, techniques, and interventions over an extended period of time (usually more than one session), for example providing an explanatory rationale, collaborative decision-making, here-and-now experiencing, empathic reflection, and cognitive problem-solving.

Another type of intervention that involves a lengthy sequence of activity is *enactment*: creating situations in which an interaction between two or more people is imaginatively acted out. The therapeutic value of enactment lies in the possibility of playing and replaying what might happen (or has happened) in social situations, in a context that has no real-life consequences. In this kind of scenario, both client and therapist are able to observe, reflect on, and discuss the options open to the client, and practise novel or preferred responses. In some instances, enactment may enable the client to get closer to the emotions that they experience in certain interactions. In other instances, enactment may allow emotional distancing to take place.

Probably the most common use of enactment occurs during the ongoing flow of therapist–client interaction, when the client describes an incident or conversation that occurred in real life. It is not unusual for a therapist to respond by asking the client to run through the episode again in more detail, or to take the role of different protagonists and express how they talked or behaved. Some therapists may even take the role of one of the characters in the drama that is being described. There is always some degree of enactment in ordinary speech, for example when the speaker quotes the words of another person, or gestures in a manner typical of that person. Therapists quite often seek to intensify and draw attention to these forms of expression, in ways that can lead to therapeutic benefit. These types of informal or idiosyncratic improvisational enactment are widely used.

Other types of enactment have been developed within different therapy traditions. *Empty chair work* is an intervention in which the client is invited to imaginatively talk to another person, or part of self, sitting in an adjacent chair. This process facilitates authentic dialogue between parts of the self, and in particular to give a voice to previously suppressed aspects of the client's experience. *Behavioural experiments* are interventions where the client tries out new behaviour in real-life situations, sometimes accompanied by their therapist. For example, a client who had panic attacks during journeys on the underground/metro, might learn how to use a relaxation, breathing, or mindfulness technique, and then try it out in a real-life situation. This kind of procedure requires an imaginative investment in viewing the experiment as a form of learning in which failure is regarded as a source of feedback and acceptable outcome, rather than as evidence of a person's inadequacy.

There are many other extended therapist interventions that use combinations of skills and techniques to achieve particular therapy outcomes. These include: using altered states of consciousness such as meditation or mindfulness; activating the client's personal strengths and cultural resources; creative and arts-based techniques; educational and information-giving strategies; facilitating client insight and understanding. For reasons of space, further detail cannot be included here. Examples of these interventions can be found in several of the chapters in Part 2 of this book.

## The experience of being a therapist

The counselling and psychotherapy literature (and the literature in allied occupations such as life coaching and career guidance) is dominated by books and articles that discuss different therapy theories and techniques and how effective they are when applied with different client groups. However, some therapists have also written about the uncertainty, confusion, and anxiety – and also occasional joy – associated with the experience of being a therapist, and the impact of this line of work on one's personal life. Some of the main themes that emerge in these reflections on the experience of being a therapist are:

- memories of personal experiences and issues being triggered by client material;
- thinking or worrying about clients between sessions;
- being burdened by a sense of responsibility for client well-being;
- being subjected to client anger or aggression;
- learning about oneself, and becoming a stronger and more resilient person, by witnessing, participating in, and being inspired by the ways in which clients develop and grow;
- being very aware of secrets, and careful about what one says to whom;
- becoming disenchanted with the world, and distancing oneself, as a result of hearing tragic stories of awful things that have happened to clients;
- becoming less able to engage in normal superficial social chat, through developing a conversational style that focuses only on deeper personal issues;
- investing time and emotional energy in clients, and having less to offer family and friends.



Behind these broad themes there are many individual stories that have been captured in therapist interviews and autobiographies. When therapists look back at their careers, they identify a mix of positive aspects of the experience of being a therapist and personal costs (Råbu et al. 2016). Working as a therapist is often described as a journey (Geller 2014; Goldfried 2001; Pruitt 2014). The American psychotherapist Iris Fodor describes a journey over the course of a rich and varied career that was influenced in important ways by coming to terms, at both personal and professional levels, with the increasing salience of feminism as a force in society (Fodor 2001, 2010, 2015). The British psychotherapist John Marzillier (2010) describes a journey from being a somewhat socially isolated schoolboy from a privileged background, through to becoming a leading behaviour therapist, then training in psychodynamic therapy, and finally becoming an integrative therapist, driven by a search for personal meaning allied to a powerful desire to do the best possible job for his clients. Some stories of therapists in mid-career highlight areas of learning that are hugely personally significant and satisfying (Hayes 2014b), often arising from the opportunity to witness client growth and development (Timulak 2014). Other stories convey the challenge of maintaining a life outside of work (Kennedy and Black 2010). Accounts written by therapists at the start of their career convey a sense of shock as the reality of being close to the despair of others and the experience of learning about terrible things that can happen to people, accompanied by a ripple effect as the implications of this new knowledge start to permeate into one's personal relationships (Butler 2014; Garrity 2011; Lyman 2014). There also exists a genre of therapist stories around specific aspects of the work, such as what it is like to be in a session with a client (Rober et al. 2008) or what it is like to be preoccupied with a client and not get them out of one's mind between sessions (Bimont and Werbart 2017).

Any occupation is likely to be attractive to individuals with specific interests and emotional needs, and will then shape that person in a particular direction. Being a therapist is no different from being a teacher, doctor, police officer, or member of any other profession that requires high levels of commitment and immersion in a particular role and set of tasks. One of the distinctive aspects of being a therapist is that the personal life experience and life history of a therapist is a resource that is used in work with clients. For example, when trying to make sense of a client who is struggling with loss, trauma, or low mood, the response of a therapist is inevitably shaped by their own experience of these topics. Being a therapist involves learning how to channel personal experience in ways that are productive for the work. In this respect, therapists are similar to artists.

## Conclusions

The aim of this chapter has been to offer an introduction to what it is like to be a therapist. The role of therapist was explored first in terms of what a therapist is expected to deliver, then through an analysis of what therapists do in order to fulfil these demands and expectations, and finally in a sketch of the personal implications of doing this kind of job. Later chapters in the book return to these themes in the context of examining specific aspects of the process of therapy within different therapeutic approaches.

An opportunity to reflect on the basic underlying structure of what a therapist does, and what it is like to be a therapist, may be useful for those who are considering entering this career: it is helpful to have a sense of what one is letting oneself in for. It may also be useful for therapists in mid-career or at the end of their careers, as a means of taking stock. Being a client in therapy can involve intense curiosity about the person in the other chair. A crucial aspect of making good use of therapy, as a client, is to take an active role in providing feedback to one's therapist. The present chapter may be of interest from a client perspective, in providing some insights into what therapists are up to, and what is potentially available from a therapist.



## Topics for reflection and discussion

- 1** The present chapter outlines many ways that therapists strive to create a space in which clients can learn and change. Reflecting on your experience as a client of therapy, how many of these things were you aware of at the time? Which of them seemed most important to you? Was there anything missing that would have made a difference to you?
- 2** In your role as a therapist, does this chapter enable you to identify your strengths and gifts – the principles, skills, and interventions around which you have a great deal of competence, confidence, and resourcefulness? Does it also help you to identify any areas for further development?
- 3** If you are at an early stage in your career as a counsellor or psychotherapist, what are the priorities, looking ahead, in terms of your personal and professional learning and development?

## Suggested further reading

A fascinating account of how one therapist goes about his business can be found in Irvin Yalom's *The Gift of Therapy: An Open Letter to a New Generation of Therapists and Their Patients – Reflections on Being a Therapist* (2002).

# Building a therapeutic relationship: working together

<b>Introduction</b>	<b>28</b>
<b>Making sense of the therapeutic relationship: multiple perspectives</b>	<b>28</b>
The relationship as container	28
The relationship as a place of authentic meeting	29
Therapist as teacher or coach	30
The author–editor relationship	30
Therapist and clients as allies	31
Maintaining mutual alignment	31
Integrative models: the all-purpose therapeutic relationship	31
<i>The responsive relationship</i>	31
<i>The five relationship model</i>	32
<i>Josselson’s multi-dimensional model</i>	32
<i>Structural analysis of social behaviour</i>	33
<i>Reflecting on images of the therapeutic relationship</i>	33
<b>The client’s internalisation of the therapist</b>	<b>34</b>
<b>Relational depth</b>	<b>35</b>
<b>Building a therapeutic relationship</b>	<b>36</b>
Small ways in which a relationship is built	36
Shared language	37
Unconscious synchrony	37
Metacommunication	38
Repairing ruptures in the alliance	38
<b>The embodiment of the therapeutic relationship</b>	<b>39</b>
Transition objects	39
The therapy room	40



<b>The boundaried relationship</b>	<b>41</b>
<b>Measuring the therapeutic relationship</b>	<b>42</b>
<b>The financial relationship</b>	<b>43</b>
<b>Conclusions</b>	<b>44</b>
<b>Suggested further reading</b>	<b>45</b>
<b>Topics for reflection and discussion</b>	<b>45</b>

## Introduction

The relationship between a therapist and a person who is seeking help lies at the heart of what therapy is about. Although a therapist uses theory to make sense of the client's difficulties, and uses techniques and interventions to address these difficulties, the fact remains that theory and technique are delivered through the presence and being of the therapist as a person: the basic tool of therapy is the person of the therapist and the capacity of the therapist to engage collaboratively with the client. Research studies have consistently found that the quality of the client–therapist relationship, as perceived by the client, is the single most significant factor contributing to the effectiveness of therapy.

The relationship between a client or patient and their therapist is probably unique for the majority of people who enter therapy. A client is exposed to a situation in which another person will listen to them for several hours, will make every effort to see issues and dilemmas from the client's perspective, will treat what is said with total respect and confidentiality, and will abstain from seeking to gratify any of their own needs during this time. There is a deep caring – and sense of being 'special' – that is unusual or even absent from the relationship experiences of most people in contemporary society.

The aim of this chapter is to offer an introduction to how to make sense of what happens in the relationship between a therapy and a client, and the issues and challenges associated with this aspect of the process of therapy. Later chapters, on particular therapy approaches, examine the ways in which the therapy relationship can be understood and cultivated within different styles of therapy practice.

## Making sense of the therapeutic relationship: multiple perspectives

The English language possesses a relatively limited vocabulary for describing relationships (Josselson 1996). Partly this is because relationships are immensely complex and hard to summarise. Any relationship between two people is played out at a number of levels: social, emotional, linguistic, physical. As a result, writers on therapy have needed to draw on images and metaphors to convey their insights into the client–therapist relationship. Some of the main ideas and images that have been influential in the therapy literature are outlined next.

### The relationship as container

The earliest attempt to make sense of what was happening in the relationship between a psychotherapist and a patient was made by Freud (Chapter 7). When, in the 1880s, Freud and Breuer began their experiments with what they called the 'talking cure', they became aware that their patients often responded to them in terms of strong emotional reactions: admiration, erotic attraction, anger,

hatred. Initially, it was hard for Freud and Breuer to make sense of why this was: these emotional responses did not seem to arise from anything in the therapy itself. Eventually, they reasoned that these reactions had their origins in unresolved childhood conflicts, desires, and emotional needs, which were now finding expression, many years later, in the safe environment of the therapy session. Freud (1917/1973) eventually came to use the term *transference* to describe this phenomenon. Freud and his colleagues then observed that these expressions of feeling on the part of the patient often triggered corresponding responses within the analyst. For example, if a patient was expressing hostility towards the therapist, they might find themselves being angry in return, or seeking to defend their actions. If a patient commented on the attractiveness of the analyst, it would be natural to feel flattered, or to become seduced. Freud and those who worked alongside him in the early years of the development of psychoanalysis came to describe these therapist reactions as *countertransference*.

For a long time, psychoanalysts tended to view countertransference as an unwelcome source of bias on the part of the therapist, and suggested that sufficient personal analysis would enable a therapist to be able to be free of these reactions, and achieve a state of absolute neutrality in response to the patient. It was only in the 1950s that countertransference came to be regarded as a valuable source of therapeutic material.

The image that is used by many psychoanalytic and psychodynamic counsellors and psychotherapists to convey their sense of the type of relationship they seek to construct with clients is that of the *container*. The relationship becomes a place within which the most painful and destructive feelings (i.e. the deepest layers of transference) of the client can be expressed and acted out, because they are held safe there. Psychodynamic therapists also draw on the image of the *frame* or *structure* to characterise the therapeutic relationship. It is only when the edges of the container are clearly defined that the client knows that they are there. If these edges are permeable or indistinct, the client will be left with uncertainty about whether their desire or rage can in fact be contained and held effectively. The image of the container itself evokes and is associated with aspects of *parenting* – for example, the parent making sure that a toddler having a tantrum does not harm themselves, or the setting of limits for teenagers experimenting with sex or alcohol. The container image also implies that, as in parenting, one of the functions of the therapist is to *frustrate* the client/child. Within the therapeutic space, it is acceptable to express any kind of desire, but not to consummate it. For instance, it is therapeutically valuable to express anger towards the therapist, such as by being late for sessions. However, if the therapist is provoked into an argument with the client ('you are wasting my time by being late every week'), the client is merely repeating a destructive pattern, and has lost the opportunity to gain insight into it. Instead, the intention in therapy is to arrive at an understanding of the meaning and origins of such patterns of behaviour, as a way of initiating a process of, over time, developing new strategies that are more constructive.

## The relationship as a place of authentic meeting

For Carl Rogers, one of the key figures in the development of counselling and psychotherapy (see Chapter 10), the image of the somewhat distanced and detached psychoanalytic 'emotional container' relationship was alien to his values and cultural experience. Rogers had been brought up in a Midwest American community that emphasised individual autonomy and equality between people, and as a result he was never comfortable with what he perceived as the expert-driven nature of psychoanalysis. He therefore used his work to promote a very different image of the kind of relationship that should exist between therapist and client.

The aim in this kind of therapeutic relationship is to move beyond the performance of a professional role, and seek to create an authentic encounter in which each participant is able to 'meet' the other. This perspective was influenced by the ideas of the philosopher Martin Buber, who believed in the transformative power of the 'I-Thou' relationship, in which the other person is experienced

without labels or conditions. This way of being involves openness on the part of the therapist to their own needs and feelings in the therapeutic encounter.

The principal relationship qualities that underpin such an approach are *presence* and *contact*. It is through being present, in the current moment, with the client that the therapist is able to be empathic, accepting, and congruent. The commitment to be fully present, in the 'here-and-now', is a continual challenge to any therapist, because it is easy to revert to evaluating the client in terms of professional and theoretical categories, to slip into thinking ahead ('What is the possible outcome?' 'Is this useful?'), or to lack the courage to respond honestly to the other. The image of the therapeutic relationship as being distinctive in its level and intensity of *authentic presence* is a crucial aspect of this stance – for the client, participating in such a relationship makes it possible to engage in honest self-exploration, as well as communicating an appreciation of the possibility of intimacy and genuineness in ordinary, everyday life settings.

## Therapist as teacher or coach

Some therapists view their purpose as that of helping the person to change their behaviour in real-life situations, typically by using structured exercises and interventions through which the client can learn coping skills. Although the relationship between client and counsellor needs to be sufficiently supportive to enable these interventions to be applied appropriately, the focus is primarily on the interventions, rather than the relationship. Rather than viewing the therapist–client relationship as a here-and-now arena in which emotional issues are expressed, or as a source of healing, the therapist is regarded as a teacher or coach. Within this perspective, the therapist is someone who supports a person in learning new skills, by demonstrating or modelling these skills, but also by reinforcing and celebrating achievements and successes, giving encouragement, and acting as a source of motivation. A good coach also promotes positive expectations, by conveying their confidence in the capacity of the student to do well. In addition, the therapist may fulfil a role with similarities to a scientist or philosopher, in seeking to question and challenge irrational beliefs held by the client. Homework assignments can be understood, within this perspective, as 'experiments' in observing the effects of new ways of behaving in social situations. The image of the 'Socratic dialogue' is sometimes used to describe the way this kind of therapist might draw on the style of the Greek philosopher Socrates, in engaging in a process of challenging, sometimes with humour, the irrationality or arbitrariness of the beliefs or patterns of logic that the client has used to create and maintain their state of anxiety or depression. A central theme within this kind of therapeutic relationship is *collaboration*: the therapist and client work *alongside* each other to find solutions to problems. Some of the metaphors that may be used by the therapist to explain this way of working to the client are that therapy is a 'team effort' or that 'two heads are better than one'. Many clients appreciate this kind of relationship, because it comes across as down-to-earth and practical, and similar to other types of relationship they might have come across in their lives. A therapist operating within a teacher/coach relationship model is likely to provide clients with a relatively high degree of structure within sessions, and focus on developing solutions to problems and symptoms, rather than exploring the inner experience of painful issues to any great extent. The therapeutic relationship may therefore be smoother and more predictable than it may at times become in therapies that adopt a 'container' or 'authentic meeting' approach.

## The author–editor relationship

A group of contemporary approaches to therapy (see Chapter 14) adopt a position that problems arise because the freedom and individuality of the person has been limited as a consequence of conformity to dominant cultural narratives that define the way the person 'should' behave in various circumstances. The goal of therapy is to enable the person to be the 'author' of their own story. The role of the therapist is to be participant-facilitator of the therapeutic conversation – in other words, to help the person to articulate their personal story as fully as possible. At the heart of this way of

being a therapist is the concept of *not-knowing*, which respects the uniqueness of each individual client's narrative truth. The role of the therapist here is to suggest strategies that the client might use to deconstruct, reconstruct, and retell their story. These strategies can involve questioning, using metaphor, writing, drawing, song-writing, and other means of expression. The relationship between therapist and client is akin to that between a writer and their editor. It is the writer who *creates* and *imagines* the story into existence; the editor helps to give it shape, and nurture it into publication. This kind of relationship is sometimes described as 'de-centred': although there is a close connection between the therapist and client, the relationship is not of interest. Instead, the aim is to enable the client to develop relational connection with people in their everyday life, by being clearer about what they stand for and who they are, and being more able to join in solidarity with those who have similar values.

## Therapist and clients as allies

Currently, one of the most pervasive and influential images of the therapeutic relationship is based on the idea of the *working alliance* formulated by Bordin (1979). The underlying assumption is that the client and therapist work together, or are allies, in the face of a common enemy (the problems and symptoms of the client). Bordin (1979) proposed that a functioning working alliance between a therapist and a client comprised three features: an agreement on *goals*; an assignment of a *task* or series of *tasks*; and the development of a *bond*. Bordin proposed that all therapy is built around goals, tasks, and bonds, even if the relative weighting of each element varies in different cases. The model outlined by Bordin has proved highly resilient in informing research and practice over a 40-year period.

## Maintaining mutual alignment

Goal alignment theory is a way of understanding the client–therapist relationship that assumes that a central aspect of being a person is *directionality*: a sense of intentionality and movement towards the future (Cooper 2019). The capacity of human beings to collaborate with each other is based on a process of shared intentionality that develops at an early age (Tomasello and Carpenter 2007). Applied to therapy, a directionality perspective suggests that if a client and therapist are to work effectively together, they need to remain in alignment around the trajectories that each of them is following, and in particular to be sufficiently aligned in relation to each other's goals. Goal alignment theory does not regard it as particularly useful to view alignment as a general characteristic or dimension (McLeod 2017a). Instead, it invites attention to specific actions or strategies that clients and therapists use to ensure that they are moving in the same direction, such as metacommunication (see later in this chapter) and feedback.

## Integrative models: the all-purpose therapeutic relationship

The images or models of the therapy relationship discussed so far reflect distinct options. However, there have also been therapy theorists who have tried to produce more integrative or comprehensive ways of understanding the relationship.

### *The responsive relationship*

Stiles et al. (1998) proposed that therapists and clients are highly sensitive and responsive to the reactions of one another. Within the moment-by-moment interaction that occurs in a therapy session, there exist complex feedback loops through which the behaviour of one participant influences, and is influenced by, the behaviour of the other. Stiles et al. (1998) suggest that the reason why all forms of therapy are broadly equivalent in effectiveness is that therapists who are trained to relate to their clients in a specific way can be gradually pulled by their clients in the direction of other relational styles (Lazarus 1993). Less effective therapists, by contrast, tend to continue to do the

same thing, no matter what signals are sent out by the client. An attempt at a model of a responsive client–therapist relationship was made by Howard et al. (1987), who proposed that it makes sense to analyse therapist behaviour, in respect of how they interact with a client, in terms of two general dimensions: *directiveness* and *supportiveness*. These dimensions combine to form four therapist *relational styles*:

- 1 *High direction/low support*. The therapist is in charge of what is happening. This style is appropriate when the client is unwilling or unable to move themselves towards the goals of therapy.
- 2 *High direction/high support*. The therapist adopts a teaching/psycho-educational role, in relation to a client who has indicated a willingness to learn. This is relational style commonly found in CBT approaches.
- 3 *Low direction/high support*. The therapist using this style is essentially accompanying a client who is engaged in a process of exploration and growth. This is the relational style associated with person-centred counselling.
- 4 *Low direction/low support*. The therapist functions mainly as an observer of the client's progress. This relational style is characteristic of classical psychoanalysis.

Howard et al. (1987) suggested that the majority of clients experience times when they need their therapist to relate to them in each of these different ways. They also suggested that the majority of therapists are comfortable and confident in only one or two of these relational styles, and that expansion of the relational style repertoire represents a key focus for training and supervision.

### *The five relationship model*

Clarkson (1990, 1995) proposed an integrative framework for making sense of therapeutic relationships, which envisaged five different kinds of therapeutic relationship, all potentially available to the therapist and client:

- 1 The working alliance.
- 2 The transference/countertransference relationship.
- 3 The reparative/developmentally needed relationship.
- 4 The person-to-person relationship.
- 5 The transpersonal relationship.

Implicit in Clarkson's model is a sense that there is a developmental movement across these relationship types: an 'alliance' is viewed as a basic functional level of communication, whereas a 'transpersonal' relationship is characterised as a 'higher-level' type of contact. Her writing is poetic and creative, rather than research-informed, and seeks to convey the distinctive emotional environment created within each of these contrasting types of relationship. In her view, all of these relationships are possible and implicit in any therapy, and training should prepare practitioners to operate comfortably across the entire range.

### *Josselson's multi-dimensional model*

Josselson (1996) constructed a model of relationship dimensions that is specifically oriented towards making sense of the types of relationship difficulties and issues that people might bring to therapy. Josselson (1996) suggested that there are eight main relationship dimensions:

- 1 *Holding* – being there for another person, allowing another person to be there for oneself.
- 2 *Attachment* – the emotional bonds, or enduring connection with another person.
- 3 *Passionate involvement* – being aroused in a relationship, being excited, feeling pleasure, being physically touched.

- 4 *Eye-to-eye validation* – affirmation, recognition of one's meaning and value in the eyes of another person.
- 5 *Idealisation and identification* – admiring another person, using them as a model or mentor, wanting to be like that person.
- 6 *Mutuality and resonance* – being with another person, joining in together, doing things together, sharing the same feelings.
- 7 *Embeddedness* – belonging, being a member of a group.
- 8 *Tending and caring* – looking after, being dependent.

Josselson (1996) takes the position that an emotionally well-adjusted person will have the capacity to engage with others along any and all of these dimensions of relationship. Conversely, a person may develop relationship difficulties, or have an absence of capability, around any of the dimensions. It is easy to see that the models of relationship discussed earlier fail to address all of the dimensions identified by Josselson (1996). For example, an authenticity-oriented approach provides a good framework for making sense of eye-to-eye validation and mutuality/resonance, while the 'container' model has a lot to say about attachment and idealisation/identification. However, neither approach has a great deal to offer when it comes to understanding relationship issues arising from passion or tending/caring. It is perhaps significant, and not surprising, that counselling/psychotherapy theories of relationship mainly consider relationship dimensions that may be directly played out within the therapy room, and perhaps lose sight of the expression of passion and caring in the lives of people with whom they are working. The implications of this model for therapy practice are discussed in Josselson (2003).

### *Structural analysis of social behaviour*

Other multidimensional models that can be used to analyse the client–counsellor relationship include the framework used in the Structural Analysis of Social Behaviour (SASB; Benjamin 1987) and the Interpersonal Octagon approach (Birtchnell 1999). This perspective specifically considers reciprocal patterns of behaviour that take place between participants in a relationship. For example, a person who has a need for controlling and maintaining order is likely to seek out relationships with people who will reciprocate through having a need for care and protection. In terms of more negative or destructive forms of this pattern of relating, it could be argued that people who behave in ways that are intimidating and sadistic will gravitate towards people who may expect rejection and disapproval. Ultimately, these reciprocal patterns can be viewed as manifestations of the interaction between how close to others (or distant from others) a person prefers to be, and their preference for being powerful and dominant (as contrasted with submissive).

### *Reflecting on images of the therapeutic relationship*

The images, metaphors, and theories of the therapeutic relationship, introduced in the preceding paragraphs, offer a range of perspectives for making sense of this crucial aspect of the process of therapy. These perspectives can be used in three main ways. First, most approaches to therapy (see Part 2 of this book) are organised around a single image of the therapy relationship: therapists who work within a particular therapy tradition therefore become highly adept at relating to their clients in a particular way. Second, in relation to therapist development, it is helpful for a therapist to be aware of their own strengths and weaknesses in terms of relating to others. For example, a therapist may be very comfortable in relating to other people on the basis of mutuality and equality, but find it hard to respond when a person idealises them, or demands to be taken care of. Each of the integrative frameworks outlined above is essentially advocating relational flexibility on the part of therapists, to enable them to be maximally responsive to their clients' relational needs. The concept of therapist *responsiveness* provides a useful means of making sense of this kind of flexibility. A third way in which images and metaphors of relationships can be useful for therapists is around the task



of making sense of patterns and themes in a client's life. When listening to the stories that a person seeking therapy tells about their life, it is valuable to be able to pick out recurring patterns of relating, particularly if the person's problems in living seem to involve relationship difficulties.

### Box 3.1: The concept of the 'real relationship'

It can be useful to think of the therapist–client relationship as comprising different elements. Many therapists think about the relationship in terms of two main elements: (1) the alliance (i.e. how the client and therapist work together to accomplish the tasks and goals of therapy) and (2) unconscious processes of transference and countertransference. Gelso (2002, 2009) suggests that there is a crucial third element, which he characterises as the 'real relationship'. The real relationship refers to the capacity of the therapist and client to meet as people, and appreciate and respond to each other as unique individuals, beyond their roles as client and therapist. Gelso (2009) argues that the real relationship comprises two main aspects: genuineness (being authentic and honest) and realism (responding to the other on the basis of how they really are, rather than projections and fantasies). In their research, Gelso and his colleagues (Gelso 2009; Gelso et al. 2005) have found that being able to establish a real relationship is an important ingredient in effective therapy.

## The client's internalisation of the therapist

As a client, one is highly sensitive to what the counsellor or therapist has to say. In all probability, the therapist says little (compared with the client's output of words), so what they do say takes on a special significance. As a client begins to speak of things that they may never have talked about before, things that have hitherto been held within an inner, private dialogue, the voice of the therapist comes to be added to the voices within that inner space. Most of us can 'hear', within us, the voices of some or all of our parents, siblings, life partner, and children. Being in therapy can often result in the addition of the voice of the therapist to this inner chorus. Geller and Farber (1993) use the term 'internalisation' to describe this aspect of the therapist–client relationship.

In a qualitative study carried out by Knox et al. (1999), 13 people in long-term therapy were interviewed about their 'internal representation' of their therapist. These clients reported a range of different types of internal representation. Some described vivid, detailed internal 'conversations' with their therapist. For others, their inner therapist was described in more dream-like terms. The frequency of occurrence of these internal images varied a great deal, with some clients using their 'inner therapist' on a daily basis, and others only monthly. One of the main themes emerging from this study was the significant degree to which clients deliberately used such internal images to continue the therapeutic process outside of sessions. For example, during moments when one client was considering self-harming, she imagined her therapist extending her arms to her, encouraging her to come to her for help and support. Another client, at times of stress, remembered a conversation with her therapist around how to problem-solve, and was thereby able to avoid having a panic attack. On the whole, the clients interviewed by Knox et al. (1999) regarded the process of internal representation of the therapist as a beneficial aspect of therapy, although some were concerned that it might indicate an overdependence on the therapist, or reflect the absence of other supportive individuals in their life. Few of these clients had mentioned these between-session experiences to their therapist, possibly because they believed that such occurrences were not 'normal'.

Wachholz and Stuhr (1999; Stuhr and Wachholz 2001) interviewed 50 clients who had completed therapy 12 years previously, within the outpatient department of the Hamburg University Hospital.

Half of these clients had received psychodynamic therapy, and half had received client-centred therapy. Some of the cases had been successful, whereas in other cases the therapy appeared to have had only limited benefit for the client. Wachholz and Stuhr (1999) found that the internalised ‘images of the therapist’ that emerged in the follow-up interviews could be analysed in terms of eight ‘types’:

- 1 *Therapist as ‘mature mother’ object.* There was a trusting relationship, which satisfied the client’s needs. Over the course of therapy, however, the client developed a more differentiated image of the therapist, as someone who had both good and bad sides. The relationship at termination was therefore both realistic and honest.
- 2 *Therapist as ‘symbiotic mother’.* The therapist is exclusively a ‘good’, warm voice that is wholly attuned to the client’s needs and never challenges the client’s attitudes.
- 3 *Therapist as ‘insufficient mother’.* The therapist fails to accept the client’s needs to be accepted and supported: ‘this permanent frustration proves intolerable for patients . . . they react by breaking off therapy, or by subsequently searching for better and more understanding mothers in countless additional therapies’ (1999: 334).
- 4 *Therapist as ‘unattainable father’.* At the outset of therapy, some women clients perceive their male therapist as the partner they have always longed for: loving, understanding, accepting. As therapy progresses, these clients become increasingly disappointed and angry, and ‘regard themselves as the victims of an obscure game whose rules they do not understand’ (1999: 334).
- 5 *Therapist as ‘stern demanding father’.* The client’s inner image is of a father whose affection and esteem they vainly struggle to win.
- 6 *Therapist as ‘devalued object’.* The client does not feel understood or accepted at all, and is internally critical of the therapist.
- 7 *Therapist as ‘repressed object’.* The client finds it impossible to re-create a detailed image of the therapist at all.
- 8 *Therapist as ‘unreachable, ideal object’.* The therapist is represented as an omniscient, wise figure who stands on a pedestal and is beyond reach.

The internalised images associated with therapists who had been ‘motherly’ in a constructive manner (types 1 and 2) were described by clients as ‘warm memories’ and ‘what they had been looking for’. All of the other internalised images were, to a greater or lesser extent, relatively unhelpful for clients. This research conveys a sense of the complexity of the therapeutic relationship, and the degree to which the client’s internalised image of the therapist is a product of the therapist’s style, the client’s needs, and the interaction between the two of them.

## Relational depth

The idea that effective therapy involves the creation of an *alliance* between client and therapist has proved to be a remarkably useful way of thinking about the therapy relationship. However, like any metaphor, the image of client and therapist being ‘allies’ to fight a common cause (e.g. to overcome the client’s problems and symptoms) has its limitations. In particular, it does not capture the quality of intense person-to-person contact that can sometimes occur in therapy. Mearns and Cooper have developed the concept of *relational depth* to begin to describe this kind of experience. They define relational depth as ‘a state of profound contact and engagement between two people, in which each person is fully real with the Other’ (2017: xii). Research into the experience of relational depth by therapists and clients (Knox et al. 2013) has confirmed the significance of this concept. Clients report that these moments have a profound and enduring healing impact on them. However, they also report that such events rarely occur.



## Building a therapeutic relationship

The images of the therapeutic relationship that have been reviewed before offer a range of different ways of making sense of what happens between a client and a therapist. It is also important to understand what a therapist actually *does* to establish a robust alliance with a client. An important strand of theory and research around the topic of the therapeutic relationship has focused on identifying and developing practical strategies used by therapists to build and maintain constructive relationships with clients.

### Small ways in which a relationship is built

Several research studies, using different methodologies, have sought to identify therapist skills and behaviours that contribute to the development of a positive client–therapist working relationship. Some of the key studies are summarised here.

A valuable series of studies into client perceptions of what their therapists do to build a relationship with them was carried out by Robinder Bedi and his colleagues (Bedi et al. 2005; Bedi and Duff 2014; Duff and Bedi 2010). In the first study, clients who had received therapy were invited to describe specific incidents or things that happened in therapy, which they believed had strengthened their connection with their therapist (Bedi et al. 2005). This generated a long list of client-defined relationship actions that fell into 25 separate categories. Among the therapist activities that were mentioned frequently were the therapist using techniques and strategies intended to produce positive outcomes, active listening, the ambience of the therapy room, and the therapist going an extra mile on the client's behalf. In two further studies, this list of therapist activities was taken to other groups of clients, who were asked to rate which of them were most important. While all of the original items were confirmed as helpful by at least some clients, the specific therapist activities that emerged as most salient for clients, in terms of developing a positive relationship, were:

- 1 my therapist validated my experience;
- 2 my therapist asked me about other parts of my life and not only about my problem(s);
- 3 my therapist was honest;
- 4 my therapist normalised my experiences; and
- 5 my therapist made eye contact with me.

The significance of the evidence from this set of studies is that it emphasises and gives voice to the point of view of the client. They show that when clients are asked about the therapeutic relationship, they are able to identify many small things that make a difference, including behaviours and attitudes that therapists themselves may not regard as being particularly noteworthy.

Other research has examined the actual behaviour of therapists in early sessions of therapy (Oddli and Halvorsen 2014; Oddli and Rønnestad 2012; Oddli et al. 2014). What was apparent in the recordings of early sessions was the extent to which the experienced therapists paid attention to the strengths of the client and the client's active efforts to make sense of and resolve their problems. This was accomplished through subtle use of language, such as the use of pauses or brief silences, and statement of uncertainty that gave space to the client to verbalise their own experience. In addition, from the start, therapists engaged clients in a process of shared decision-making, and introduced interventions that addressed the client's difficulties. The overall picture to emerge from this research was of intensive therapist effort to work 'alongside' or 'with' their client.

A further research initiative in this area has been the development of the Alliance in Action (AiA) scale (Owen et al. 2013), a brief questionnaire that can be completed by clients to indicate the extent to which their therapist is engaging in activities that help to build a collaborative relationship. The stand-out item from this questionnaire, which emerged as highly meaningful for most clients as an indicator of a productive client–therapist connection, was the statement 'my

therapist and I talked about how I thought our relationship was going'. Conversely, two other statements included in the scale were markers of an unproductive relationship: 'my therapist conducted therapy in his/her own way, regardless of my input' and 'my therapist was not interested in my feedback about his/her approach'. The importance of 'my therapist and I talked about' lies in the fact that scrutiny of most therapy transcripts and recordings suggests that therapists seldom initiate explicit conversations around how the client thinks the 'relationship is going'. In addition, almost all of the evidence that exists around the significance of the therapy working alliance is based on questionnaires that ask clients about whether they believe that there is client-therapist agreement around therapy goals and tasks, without asking whether this agreement is informed by an actual discussion of the topic.

In acknowledgement of the value of client-therapist conversations that look at the 'small things' that make a difference in this area, brief questionnaires have been developed that the client can complete towards the end of a session that allow the client to highlight therapist actions that can then be discussed and if necessary modified in following sessions. The main scales that have been used in this way are the Session Rating Scale (Miller et al. 2016), the Client Feedback Form (Bowens and Cooper 2012), and the Cooper-Norcross Inventory of Preferences (Cooper and Norcross 2016).

## Shared language

A key task within the process of building a therapeutic relationship is the creation of a shared language (Hobson 1985), particularly around the use of feeling words and action words. It is likely that client and therapist each possess slightly different vocabularies and ways of talking. For effective communication and collaborative action to occur, these personal languages need to be aligned. Particularly marked contrasts in language use may occur when client and therapist have different class or ethnicity backgrounds. When one or both participants in therapy are bilingual or multilingual, language switching may take place. For example, clients who are not native English speakers may switch back to their first language to express emotion, or when talking about early family experiences.

Creating a shared language can involve a wide range of factors, including word choice, voice quality, pace of speech, and use of silence. The use of metaphor represents an area in which effective linguistic alignment may be readily apparent. Normal speech patterns tend to involve the production of a large number of both conventional and novel metaphors. The ability of client and therapist to jointly explore the meaning of a novel, vivid metaphor over a number of speaking turns is an indicator of a productive therapeutic relationship (Angus and Rennie 1988). Another linguistic accomplishment that helps to build a therapeutic relationship is positive humour. Sarcastic, aggressive, and avoidant humour do not make a valuable contribution to therapy. However, shared moments of humour and laughter have the potential to bring therapist and client closer in a positive shared experience, as well as enabling the release of emotional tension and in some instances allowing the client to gain a fresh perspective on their problems (Fox 2016; Gladding and Wallace 2016; Thomas et al. 2015).

## Unconscious synchrony

For many therapists, the attempt consistently to respond empathically to a client lies at the heart of the kind of relationship they seek to offer. Within the counselling and psychotherapy literature, empathy has generally been understood in terms of sensitivity to the language used by the client. Therapist training has tended to emphasise the development of skill in responding appropriately to verbal cues. Over the course of his career, one of the key figures in empathy research, John Shlien, came to the conclusion that responding fully and empathically to another person required not merely a verbal response, but a 'whole-body' reaction that took account of sources of information (e.g. cellular, glandular, olfactory, autonomic, postural, gestural, and musical-rhythmical) that were transmitted largely outside of conscious awareness (Shlien 1997). In recent years, the

availability of unobtrusive recording technology has established the existence of important channels of client–therapist communication in the form of synchrony in autonomic responses, facial micro-expressions, and whole-body movement. This area of research is discussed more fully in Chapter 19. These findings highlight the importance of therapist genuineness or authenticity as a factor in the therapeutic relationship, because they imply that it may be futile or even confusing to clients to try to conceal such responses. The results also suggest that activities that enhance the body awareness of therapists, and the use of video recordings in therapist training and supervision, may play a useful role in therapist development.

## Metacommunication

Metacommunication refers to the activity of pausing the ongoing flow of communication, in order to reflect on what is happening at that moment, where the conversation is heading, and checking out the state of the relationship between speakers. On the whole, therapists do not engage in metacommunication to any great extent within therapy – this is a neglected skill. For example, Kiesler (1988) concluded, as a result of his research into this topic, that the role of therapist metacommunicative feedback to the client has been ‘almost universally overlooked’ in the individual psychotherapy literature. Kivlighan (2014) has argued that metacommunication is one of the most valuable skills in a therapist’s repertoire, which consistently emerges in research studies as being both facilitative of client learning as well as being a core element of a collaborative therapeutic relationship.

Although the concept of metacommunication has been understood slightly differently within different approaches to therapy (Kiesler 1988; Laing et al. 1966), the perspective developed by Rennie provides an effective synthesis of existing thinking on this topic. Rennie (1998: 89) defined metacommunication as follows: ‘the act of communicating about communication . . . stepping outside the flow of communication to appraise it’. Examples of therapist-initiated metacommunication include moments when a therapist:

- talks about their own plans, strategies, and assumptions;
- asks the client to focus on their plans, strategies, and assumptions;
- shares their assumptions about what the client thinks and intends;
- invites the client to share their assumptions or fantasies about what the therapist thinks or intends;
- reviews the relationship in all these ways when stuck, or in a therapy ‘crisis’;
- explores the impact of the client on the therapy (the feelings, action tendencies, and fantasies that are evoked by the client’s behaviour);
- explores the impact of the therapist on the client.

Each of these ways of talking opens up a layer of the ‘unspoken’ or implicit relationship between therapist and client, and makes it possible for both participants in that relationship to reflect on what is happening between them, and if necessary change it. The use of metacommunication on the part of the therapist positions the client as someone who has their own plans, intentions, and responses, in which the therapist is deeply interested. This kind of conversational interaction has the effect of conveying the therapist’s affirmation and respect for the client, while helping them both to achieve sufficient interpersonal alignment to accomplish therapeutic tasks.

## Repairing ruptures in the alliance

It is rare for a therapist and client to meet, form a good working relationship, and then continue through several sessions of therapy without any challenge or disruption to the bond between them, or their agreed goals and tasks. This kind of ‘ideal’ relationship (in therapy as in any other area of life) is a myth. What is more usual is for the relationship, and the therapeutic work, to ‘hit the buffers’

now and again. Participants in therapy – both clients and therapists – may report that they have reached an ‘impasse’, or that there has been a ‘rupture’ in the relationship. In these circumstances, it is necessary for the therapist to be able to call on strategies to help ‘repair’ the relationship.

A significant amount of theory and research has begun to address the question of how best a therapist or counsellor can repair or retrieve the therapeutic relationship when it goes through a bad patch. The work of Jeremy Safran and Christopher Muran (Safran 1993a, 1993b; Safran and Muran 1996, 2000a, 2000b, 2001) has been at the forefront of attempts to investigate the processes and implications of ‘ruptures’ in the therapeutic alliance.

Eubanks-Carter et al. (2010) identified a series of steps or stages that can be observed in the effective repair of a therapeutic alliance. First, the therapist needs to be sensitive to the presence of rupture in the alliance. Typically, a client will display *confrontation* (anger with the therapist or criticism of the progress of therapy), *withdrawal* (disengagement from the therapist or the therapeutic process), or a combination of the two. The task of the therapist at this point is to draw attention to what is happening within the here-and-now relationship, for example by asking ‘What are you experiencing . . .?’ or ‘I have a sense that you are withdrawing from me. Am I right?’ The acknowledgement by both the therapist and the client that there is a difficulty moves the repair process on to the next stage, which involves helping the client to describe their negative feelings, or what it is they believe is blocking them or hindering progress. The therapist may need to acknowledge at this point, in a non-defensive way, how they might be contributing to the rupture. The final stage involves encouraging the client to access their primary feelings (typically anger or sadness), and to express to the therapist their underlying needs or wishes. One of the tasks of the therapist at this stage is to affirm the importance of these needs and wishes. The single most important strategy for the therapist when there is a rupture in the alliance is metacommunication – standing back from what is happening, naming and discussing the problem, and then negotiating around it.

Successfully resolving a rupture in a therapeutic alliance can have a number of benefits for the client. Clearly, it strengthens the relationship, and makes it possible to continue therapy in a productive direction. But it also gives the client an opportunity to learn about how to sort out relationship difficulties in general, and how to ask/demand what they need in a relationship. For people who may be more familiar with rivalrous, conflict-ridden relationships, it provides a model of collaborative give-and-take relatedness. Confidence and competence on the part of the therapist around the task of rupture repair enables them to take chances throughout the process of therapy, rather than adopting an over-safe therapeutic style that avoids any risk of upsetting the client.

Taken as a whole, the literature on ruptures in the therapeutic alliance contributes to an appreciation of the value in therapy of being able to face up to, and learn from, tensions within the client–therapist relationship. These models reinforce the key idea that, for clients, the interpersonal arena of therapy provides unique opportunities for learning about needs and relationships in ways that can then generalise to everyday life.

## The embodiment of the therapeutic relationship

The quality of a client–therapist relationship is most readily observable in the way they talk together, their non-verbal behaviour, and their expression of emotion. However, therapy takes place in a tangible physical setting, and important insights into relational dimensions of therapy can be gleaned from consideration of the physical ‘props’ that accompany the work of therapy. Physical objects can carry many different kinds of meaning that may be therapeutically significant (Solway et al. 2016).

## Transition objects

The British psychoanalyst D.W. Winnicott undertook a great deal of observation of the emotional and social behaviour of young infants. He noted that, from about the age of six months, a young

child may come to have a favoured possession, such as a teddy bear, blanket, or bundle of wool, which appears to represent its 'emotional security'. If the object is lost or taken away, the child exhibits a grief reaction. Winnicott reasoned that the object represents the security of the mother's breast, and operates as a defence against anxiety during the period where the child is being asked to move away from its symbiotic relationship with the breast, and become a more autonomous individual. Winnicott coined the term *transition object*, in recognition of the important role of such objects at this crucial stage of transition in the child's life. Winnicott's account of the dynamics of transition objects is explained in his popular book *Playing and Reality* (Winnicott 1971).

A transition object represents a physical embodiment of a relationship. When the other person is not available, the object can remind us of their continuing existence and qualities. Sometimes, when a client in therapy develops a strong relationship with their therapist, they may wish to possess some object that will remind them of the therapist, and perhaps bring strength between sessions. This phenomenon is known to most experienced therapists (and clients), but has seldom been studied in a systematic manner. Arthern and Madill (1999) interviewed six experienced therapists (three gestalt therapists and three psychodynamic therapists) about their understandings of the role of transition objects in their relationships with clients. Although not selected on the basis of having been known to use or promote transition objects, all of them could recall examples of the use of transition objects by their clients.

These therapists considered that transition objects were particularly helpful for clients who experienced separation anxiety between sessions, and who were working on painful interpersonal issues, and needed to 'internalise a sense of a nourishing relationship'. They believed that the objects served not only to remind clients of the existence of a safe, constant relationship in their life, but also provided something to 'play' with, in the sense of reflecting on the meaning of the object, and using it as a trigger for learning about personal needs and relationship patterns. The therapists interviewed in this study reported a wide range of objects, including greetings cards and postcards (written from therapist to client), formal letters, books and pens, through to a soft toy, a therapist's cardigan, and a piece of a therapist's jewellery.

## The therapy room

The location of therapy can have a profound influence on the client–therapist relationship. For example, therapy sessions that take place out of doors (see Chapter 17) may bring client and therapist together in a shared experience of hardship (if it rains) or of joy (if they encounter a breathtaking view). The aspects of physical location to have received most attention are the characteristics of design, layout, and furnishing of the therapy room, including light, sound, smell, colour, temperature, as well as overall aesthetic quality and display of art work (Jackson 2018; Pearson and Wilson 2012; Pressly and Heesaker 2001).

The philosopher, social critic, and co-founder of gestalt therapy, Paul Goodman, commented on the significance of the seating arrangements associated with different approaches to therapy. For example, he suggested that the room layout in classical Freudian psychoanalysis, where the patient lies on a couch with the analyst sitting in a chair at the head of the couch, out of the patient's line of sight, had the effect of 'by-passing' the actual relationship between patient and therapist and forcing a transference-based 'infantile' relationship (Goodman 1962). A more balanced analysis of the pros and cons of 'sitting' versus 'lying' can be found in Holmes (2012).

The significance of the physical environment within which therapy takes place was investigated in a series of studies in which clients and therapists were shown photographs of different therapy rooms (Devlin and Nasar 2012; Devlin et al. 2014; Nasar and Devlin 2011). There was a general tendency to prefer rooms that were soft, comfortable, personalised, and tidy, and to have a more favourable impression of therapists who would work in such spaces. Fenner (2011, 2012) gained a more in-depth understanding of the meaning of therapy room design by interviewing clients and therapists. What was most clear, in the findings of this study, was the extent to which both clients and therapists had a relationship with the room. Clients talked about how they interpreted



the decoration and furnishing in the room as evidence for similarities between their own taste and values and those of their therapist. Clients felt deep connection with certain parts of the room, or objects in the room. The ability to look out of a window was particularly important for some clients, because it allowed them a wider horizon. In interviews where private-practice therapists described their intentions around design of consulting rooms, Jones (2018) found that most participants were aware of explicitly using room design, decoration, and layout to communicate therapeutic messages and to reveal and/or conceal aspects of themselves.

What seems clear is that clients experience the therapy room as an expression of the therapist, and that their relationship with the room is an important element in the overall therapeutic relationship. In addition, aspects of the design, layout, and aesthetic quality of the room have an impact on the process of therapy, which in turn affects the depth of the therapeutic relationship.

## The bounded relationship

One useful way to begin to make sense of the relationship between a therapist and client is to consider the way in which the *boundary* between the two participants is created and maintained. Although the concept of boundary was not used by any of the ‘founders’ of therapy (e.g. Freud, Jung, Rogers), it has become widely used in recent years as a means of describing important aspects of the therapeutic relationship. In common sense terms, a boundary marks the limits of a territory, and the line where one territory or space ends and another one begins. In counselling and psychotherapy, the concept of ‘boundary’ is clearly a metaphor – there are no actual boundary posts, markers, or lines laid out in a therapy room.

In therapy, boundaries can be identified in reference to a range of different dimensions of the relationship. For example, there are relationally focused boundaries related to:

- *Physical space* – how close (or far apart) should the client and therapist sit, how extensive is each participant’s ‘personal space’?
- *Information* – how much should the client know about the therapist?
- *Intimacy* – is touching permitted?
- *Social roles* – how does the therapist respond to the client if they meet in a setting other than therapy?
- The extent of *shared decision-making*.

Therapists differ in personal style, with some favouring strictly regulated boundaries, while others are more flexible. Some therapists may ‘loosen’ their boundary in the later stages of therapy with a client, as a more ‘real’ relationship is established. A key question is: what is the optimal set of boundaries for each specific therapist–client relationship? As Hartmann (1997) has shown in his research studies, individuals have different boundary needs or boundary ‘thickness’ or ‘thinness’: the boundary setting that may be right for one client (or therapist) may not be right for another.

It is generally agreed within the counselling and psychotherapy community that it is helpful, and avoids unnecessary confusion for clients, if the therapist defines a clear set of boundaries within which the work can proceed. There is less agreement around how best to make sense of occasions when these boundaries are not maintained, for example if a client is persistently late for sessions, or becomes preoccupied with learning about the therapist’s personal life. For some practitioners, any boundary lapse is viewed as highly problematic, and as an all-or-nothing *violation* of the therapeutic space. By contrast, other practitioners make a distinction between boundary violations and boundary *crossings* (Gutheil and Gabbard 1993).

Glass (2003: 433) defines boundary crossings as ‘benign, discussable, non-progressive departures from an established treatment framework that are creative and conscientious attempts to

adapt the treatment to the individual patient'. He describes an example of a boundary crossing with one of his own clients, a man who had been in therapy with him for several years. The client invited him to attend his first poetry recital, a major event in his personal development. Glass discussed the situation with the client, and decided to accept the invitation. The therapist 'sat in the back row, and left without interacting with other attendees or formally greeting (the client), beyond making eye contact' (2003: 437). This event was not 'progressive', in that it did not lead to a 'slippery slope' of ongoing social contact and erosion of the distinctiveness of the therapy relationship. On the basis of this kind of example, Glass (2003: 438) suggests that the client-therapist relationship, particularly in long-term therapy, is shaped not only by the boundaries that are initially defined by the therapist, but also by how the client and therapist are able to work together (or not) to deal with the accumulation of boundary crossings that occur over the course of therapy.

Therapist-initiated boundary violations (e.g. therapist sexual intimacy with a client) can be viewed as a distortion or corruption of the therapeutic relationship. Further discussion of ethical aspects of therapy boundaries can be found in Chapter 29.

### Box 3.2: The therapeutic significance of the relationship

Several of the themes explored in the present chapter come together in a study conducted by Sandberg et al. (2017) that was based on intensive interviews with clients who were in therapy to deal with experiences of interpersonal trauma. These individuals had developed a range of symptoms and life difficulties because they had been treated abusively and cruelly by other people. As a result, it was particularly hard for them to enter into a therapeutic relationship. This research study provides a good example of the capacity of qualitative inquiry to give voice to the experiences of vulnerable informants. These clients talked about the healing effect of being accepted and validated by their therapist, being able to have someone in their life who was reliable and trustworthy, with whom they could learn to laugh again, and who was willing to challenge them when they tried to avoid talking about painful experiences.

## Measuring the therapeutic relationship

A great deal of research has been carried out around the topic of the therapeutic relationship. This research has powerfully confirmed the importance of the therapeutic relationship as one of the key factors that make a significant contribution to the success of therapy with a client.

Although some qualitative, observational, and case study research into relationship processes have been carried out, most of the research in this area has consisted of statistical analyses of questionnaires completed by therapists and clients. Several questionnaires have been devised to measure dimensions of the therapeutic relationship. The person completing such a questionnaire is required to indicate the extent to which they agree or disagree with a series of statements that reflect general impressions of the relationship, typically using a 5-point scale. Versions of most of these questionnaires have been developed for therapists, clients, and external observers (e.g. listening to a tape recording of the session) to complete. Normally, the questionnaire is completed by the therapist or client immediately following the end of a session.

The most widely used questionnaires are: the Working Alliance Inventory (WAI; Horvath and Greenberg 1986, 1994), which measures Bordin's bond, task, and goal dimensions; the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard 2014), which assesses the Rogerian core conditions; and the Penn Helping Alliance Scales (HA; Alexander and Luborsky 1986), which

evaluates the overall strength of the helping alliance between counsellor and client. The Session Rating Scale (SRS; Duncan et al. 2003; S.D. Miller et al. 2005) is an ultra-brief (4-item) visual analogue scale, designed for easy use within routine counselling practice. Other measures that explore similar constructs include the Patient Experience of Attunement and Responsiveness Scale (PEAR; Snyder and Silberschatz 2017), the Alliance Negotiation Scale (ANS; Doran et al. 2012), and the Therapeutic Distance Scale (TDS; Mallinckrodt et al. 2015).

The association between client–therapist relationship and outcome has been demonstrated in a large number of studies. In addition to documentation of the importance of the therapeutic alliance, another striking finding to emerge from research has been that there are often low levels of agreement between the client, the therapist, and external observers on how they rate the therapeutic relationship in any individual case. It seems as though the different participants in therapy have quite different ways of interpreting the same events, or different criteria for judging these events. Another conclusion generated by research has been that there is a great deal of overlap between all of the therapeutic relationship scales, and between the subfactors (e.g. bond, goals, and tasks) within these scales. The implication here is that clients, in particular, may have a sense that their relationship is ‘good’, but are vague about the various dimensions that may constitute that ‘goodness’. A comprehensive review of research into the therapeutic relationship can be found in Flückiger et al. (2018).

The process of developing a valid and reliable questionnaire is time consuming and intricate. Essentially, the aim is to create a questionnaire with the smallest possible number of carefully worded questions. The task of the test compiler, therefore, requires checking with many people in order to arrive at a set of statements that accurately capture the meaning of the factor that is being measured (or ‘operationalised’).

## The financial relationship

The issue of payment can have a significant impact on the relationship between a therapist and a client. In a relationship in which a person talks about an emotional difficulty or crisis to a friend or family member, the question of payment does not arise. The implicit assumption, when using a friend in this way, is that the relationship is reciprocal: at some point in the future the roles will be reversed. Clearly, counselling and psychotherapy are not like this. Although the experience of being listened to, and being encouraged to explore feelings, may be very similar, in the end the therapist is there not because of feelings of friendship or family loyalty, but because they are, in some way or another, being paid or otherwise rewarded to be there.

The hidden nature of the financial relationship between therapist and client ultimately derives from the high level of secretiveness and ambivalence that exists in most modern industrialised societies in relation to the topic of money. For most people, the incomes and savings of even their closest friends and family members remain unknown. Yet, at the same time, we live in a society in which financial success is highly valued.

Within the counselling and psychotherapy literature, a number of different ideas have been proposed concerning the effect of payment and fees on the therapeutic relationship. First, Freud and other psychoanalysts have argued for the ‘sacrificial’ nature of the fee. The assumption here is that, as a means of maximising the motivation of the patient for therapy, and signalling the importance of their commitment to therapy, a fee should be set that is the maximum affordable by the patient. This implies that sliding fees should be operated: a fee that represented a major personal commitment for one client might be insignificant for another, more affluent client. From a psychoanalytic perspective, it has also been argued that the fee is a therapeutic tool that symbolises the strict boundaries within which therapy is conducted: no matter what happens, the fee must be paid. The existence of the fee also makes a bridge between therapy and the ‘real’ world, and provides motivation for completing therapy rather than becoming dependent on the therapist. From a psychodynamic



perspective, therefore, the fact of a client directly paying a fee makes a positive contribution to the therapeutic process.

However, it is also possible to argue that direct payment can have a counterproductive impact on the therapeutic relationship. A client who is paying for therapy may doubt the authenticity of their counsellor's acceptance: 'he/she is only pretending to value me because they are being paid' (Wills 1982). If a therapist's income is contingent on a client remaining in therapy, he or she might subtly find ways to prolong treatment (Kottler 1988).

Being involved in the collection of fees is a role that many therapists find troubling. Some therapists experience 'fee guilt' arising from the conflict between being wanted to be perceived as a 'helper' and being involved in a business that involves making a living and a profit. Counsellors and psychotherapists in private practice often report conflict around negotiating and charging fees, sending out reminders, and so on. Jabłoński et al. (2015) argue that a process of increasing 'financialisation' is gradually eroding the core values of therapy.

If psychoanalytic theory around the 'sacrificial' role of direct fee payment is correct, there should be evidence that therapy is more effective when fees are paid by clients, as opposed to when a third-party is paying (e.g. student counselling in a university, workplace counselling) or the therapist is working for free. However, there is no such evidence for a difference in effectiveness (Herron and Sitkowski 1986) based on studies that have made comparisons between fee payment and free services. Moreover, there is a lot of evidence that counselling and psychotherapy provided within workplace counselling schemes or state-run health services in Britain and other European countries (which are free at the point of delivery) are just as effective as therapy that is delivered in classical private practice settings.

The question of money represents a challenge to the therapeutic relationship because unspoken thoughts and feelings about money can impede the openness and collaboration between client and therapist. The financial dimension of the therapeutic relationship is problematic for many therapists, because the social and cultural meaning of money is an issue that has been largely neglected within therapy theory, research, and training. There is some evidence that demystifying the role of money in therapy, and instead treating it as one among many aspects of the therapy relationship, has the potential to lead to better client outcomes. Stanley et al. (2016) reported positive results from using financial incentives to keep clients attending and actively involved in the therapy process. Thompson et al. (2017) have developed workshops for trainees around engaging productively with clients around negotiation of sliding fees in community clinics.

## Conclusions

The theory and research discussed in this chapter reflect the importance of being able to view therapy from a relational perspective. There is a pervasive tendency in the therapy literature to envisage therapy as a matter of facilitating learning and change at an individual level. A therapy relationship can be regarded as similar, in its meaning and influence, to other significant personal relationships such as those that occur between parents and children, spouses, lovers, friends, and work colleagues. Reflection on the experience of such everyday relationships makes it clear that they are complex in the sense of operating at different levels, that change over time. It does not do justice to a marital or parental relationship to try to reduce it to a few key variables. Likewise, one of the key messages of the current chapter is that an understanding of the client–therapist relationship requires a capacity to look at it from different angles and to accept that it is never possible to make complete sense of what is happening: there is always an emergent dimension or edge to any genuine relationship between two persons. By contrast, a position of total understanding reduces the other person to the status of an object. Later chapters in the book explore the ways in which therapy relationships are conceptualised and created within different therapy approaches and traditions.



## Topics for reflection and discussion

- 1 Think about a person who has helped you to overcome or resolve an emotional issue in your life. How would you describe your relationship with that person? Think about someone you know but from whom you would be very reluctant to seek emotional support. How would you describe this relationship? How well can these personal experiences be explained in terms of the models and images of therapy relationships introduced in this chapter?
- 2 Research mentioned in this chapter has shown that a good relationship between therapist and client, in the early stages of therapy, is highly predictive of a good outcome at the end of therapy. Does this finding necessarily mean that the relationship is the cause of the eventual outcome? How else might you explain the fact that clients (and therapists) who give positive ratings of the strength of the 'therapeutic alliance' at the third or fourth session of therapy also report, several weeks later, that therapy has been successful?
- 3 Many counsellors and psychotherapists working in private practice operate a 'sliding fee' system, where what the client pays is adjusted according to their income and circumstances. In some situations, clients may suggest that they pay their therapist in goods and services rather than money. For example, a client who is a farmer may be able to offer produce of a higher value than any possible cash payment that they could afford. What are the potential implications for the therapeutic relationship of establishing a barter contract?
- 4 Safran and Muran (2001) argue that conflict between a therapist and client reflect what they regard as fundamental dilemmas of human existence – the tension between the need for agency/autonomy and the need for relatedness/connection. They suggest that working through these needs, in the context of therapy, has the potential to transform a client's life. How useful do you find this way of understanding relationships? Reflect on a relationship you have experienced that has been difficult. Was there a tension within that relationship between the need for agency (being in control, following your own purposes and intentions) and the need for relatedness (being in contact) for both you and the other person? Was this tension resolved (or could have been resolved) through a process similar to Safran's model of resolution of therapeutic ruptures?

## Suggested further reading

A short paper that thoughtfully explores many of the issues discussed in the present chapter is Hill and Knox (2009). *Between Therapist and Client: The New Relationship* by Michael Kahn (1997) captures the essence of the therapeutic relationship in a sensitive and highly readable manner. Although *The Space between Us: Exploring the Dimensions of Human Relationships* by Ruthellen Josselson (1996) is not specifically a book about counselling and psychotherapy, it includes examples drawn from therapy, and provides a 'map' or conceptual framework for understanding relationship issues that is highly relevant for both therapists and users of therapy. *Psychotherapy Relationships that Work* (Norcross 2011) includes authoritative reviews of current research into key aspects of the therapy relationship, written by leading figures in the field. In *Developing the Therapeutic Relationship: Integrating Case Studies, Research, and Practice* (Tishby and Wiseman 2018), experienced therapists use case examples to explain how they combine relationship and technique in their work with clients.

# Chapter

# 4

## The process of therapy: the beginning

<b>Introduction</b>	<b>46</b>
<b>Therapy as a process</b>	<b>47</b>
<b>A framework for understanding process</b>	<b>48</b>
Conversation as the core process of therapy	49
<b>Starting therapy: practical issues</b>	<b>51</b>
Informed consent	51
Negotiating expectations and preferences	51
Preparation for therapy	52
Assessment	53
Diagnosis	55
Agreeing goals	57
Case formulation and contracting	57
Introducing feedback measures	58
<b>Starting therapy: the interpersonal process</b>	<b>59</b>
<b>Conclusions</b>	<b>60</b>
<b>Suggested further reading</b>	<b>61</b>
<b>Topics for reflection and discussion</b>	<b>61</b>
<b>Suggested further reading</b>	<b>61</b>

### Introduction

The concept of 'process' is central to an understanding of what counselling and psychotherapy are about. This chapter, and the two chapters that follow, offer an introduction to making sense of the processes that occur within three broad stages of therapy: beginning, middle, and end. Chapters in Part 2 provide further insights into these themes in relation to different approaches to therapy. The present chapter is divided into two sections. First, a framework for understanding therapy process is outlined. Second, there is an exploration of the process of starting therapy.

## Therapy as a process

The concept of ‘process’ is a broad term that is grounded in a way of thinking about something that emphasises the existence of change rather than remaining the same. Anything that exists can be regarded from two contrasting aspects: as a static entity, and as an entity that is undergoing change. For example, from one perspective a table looks the same, and serves the same functions day after day. From another perspective its colour, surface characteristics, and stability are gradually altering. From one day to the next the table looks the same. From one decade to the next, it is clear that processes of ageing and deterioration through use have taken place. Each of these processes can be investigated and understood, for instance with the aim of taking action (e.g. re-varnishing or making repairs) to ensure that the table remains functional for as long as possible.

This broad conceptualisation of process provides a starting point for appreciating why process is such an important idea in therapy. A person who engages in therapy is a static entity – their basic identity, body, and demographic markers are unlikely to change during their time in therapy. However, their purpose in entering therapy is to change. This change is not a single event, such as cutting a table in half with a chain saw. Change in therapy occurs bit by bit – it is a process.

The term ‘process’ is used in the therapy literature in different ways. The actual process is complex and multifaceted. The main ways in which ‘process’ is used in the therapy literature include:

- *Broad definition.* Any activity involving change can be described as being a ‘process’. This meaning of the term merely refers to the idea that what happens in therapy is not static, and that some sort of sequence of events occurs.
- *Ingredients.* This meaning of ‘process’ has been employed mainly in the research literature, to refer to a very wide set of factors that may promote or inhibit therapeutic effects in clients. This use of the term contrasts ‘process’ with ‘outcome’: therapeutic ‘processes’ are the ingredients that contribute to outcomes.
- *An essential quality of being human.* This way of understanding ‘process’ is found mainly within humanistic perspectives on therapy. This definition characterises process as an essential human quality of being and becoming (Rogers 1961). This way of understanding process, almost as a value dimension, is also expressed by contemporary narrative social constructionist therapists. For example, Anderson and Goolishian (1992: 29) describe their aim in therapy as being ‘to facilitate an emerging dialogic process in which “newness” can occur’. This sense of process, as moments of flowing newness where ‘nothing is fixed’, represents an important way in which the concept is used by many therapists.
- *Doing and making.* A fourth sense of ‘process’ characterises the work that clients and therapists do together. Therapy is viewed as similar to a manufacturing process, in which raw materials are transformed into finished, usable products. For instance, the *emotional processing* model employed by Greenberg et al. (1993) involves ‘doing things’ to and with emotions: naming them, expressing them, reflecting on their meaning.

There would appear to be little value in attempting to nominate any one of these definitions of ‘process’ as more valid than the others. Each of these meanings of process is used by practitioners and theorists. We cannot ignore them – they sensitise us to aspects of process that are meaningful. These ideas all refer, in different ways, to an underlying sense that therapy is concerned with change, and that at some level this change is created by the actions and intentions of both the client and the therapist working collaboratively.

Therapy process represents a huge topic. There are many different processes that have been studied in therapy research or are hypothesised within therapy theories as significant ingredients of therapy (see Table 4.1). Each of these processes can be explored from the point of view of the client or the therapist, or through the eyes of an external observer.

**Table 4.1:** Therapy process factors: an incomplete list

Client role preparation	Autonomic nervous system responses
Client suitability	Gateways
Client expectations and preferences	Reflective function, metacognition
Therapist authenticity and empathy	Forgiveness, compassion
Personality, age, social class, ethnic, and gender match between client and therapist	Focus during therapy on life problems and core personal relationships
Willingness of therapist to talk about race and culture	Extent of therapist adherence to a training manual
Therapist skills	Humour
Immediacy	Sudden gains/losses
Assimilation of problematic experience	Facial expression
Stages of change, motivation	Accuracy of transference interpretations
Between-session experiences	Frequency of transference interpretations
Tummy rumbling	Client adherence to homework instructions
Goal consensus	Therapeutic working alliance
Conversational strategies and sequences	Ruptures in the therapeutic alliance
Emotion	Impasse between client and therapist
Meditation, mindfulness, yoga	Use of metaphor
Feedback	Client expressiveness and openness
Trust	Therapist self-disclosure
Touch	Change events/episodes/tasks
Challenge, confrontation	Case formulation
Use of art materials, technology	Client deference to the therapist
Courage	Treatment duration
Innovative moments	Fee structure
Therapy room design	

## A framework for understanding process

While acknowledging the complexity of the therapy process, it is also useful to be able to anchor our discussion of this topic in a conceptual framework that can be applied as a starting point for reflecting on therapy practice and experience. There are three key principles that are helpful when thinking about the process of therapy:

- 1 A process is a sequence.
- 2 Pay attention to therapist and client intentionality.
- 3 Identify process in terms of time units.

*A process is a sequence.* A process always involves something leading to something else. For example, an empathic response can be defined as a statement in which the therapist attempts to convey their understanding of the meaning for the client of whatever it is they have been talking about. The empathic *process*, on the other hand, involves a description, at the very least, of what happens after the therapist has made an empathic response (see Chapter 10). Implicit in the notion of sequence is an assumption that there is a causal link between the first event and the second one – they have not occurred at random. Many different types of causal sequence can be identified (see, for example, Haynes et al. 2012). While some analyses of therapy process focus on simple sequences, others try to make sense of extended series of events.

*Pay attention to therapist and client intentionality.* At the end of the day, making sense of the therapy process is not an abstract or intellectual exercise. Instead, it aims to lead to a better understanding of the choices that are available to clients and therapists, that allow them to maximise the helpfulness of therapy. For example, there is a lot of evidence that collecting feedback from clients on the progress of therapy can lead to better outcomes (see Chapter 5). However, it only leads to such outcomes if the therapist makes certain choices around how to respond to the feedback (e.g. exhibiting genuine curiosity about client concerns). If the therapist makes other choices (e.g. dismissively re-interpreting client negative feedback because it is personally too threatening and upsetting to take it seriously), then the process goes in a different direction (poor outcomes). Many areas of process analysis refer to processes that are out of the conscious awareness of the therapist or client, such as studies that have examined processes that take place around momentary shifts in facial expression (see Chapter 19). However, even here the aim is to open up potential areas in which the ambit of therapist or client self-awareness and purposeful action can be extended: once a therapist has learned that reflexive smiling in response to a client's smile may, in some circumstances, be unhelpful, they can catch themselves doing this and possibly do something different instead.

*Identify process in terms of time units.* It is useful to think about therapeutic processes in terms of their duration (Elliott 1991):

- *Speaking turn*: the response of one speaker surrounded by the utterances of the other speaker. This can be regarded as a *microprocess* that may last for no more than one or two minutes.
- *Episode*: a series of speaking turns organised around a common task or topic. This process unit is sometimes described as a *therapeutic event*, and can last for several minutes.
- *Session*: the entire course of a single therapy session.
- *Phase or stage*: a set of sessions with an identifiable theme or goal (e.g. ending).
- *Treatment*: the entire course of a treatment relationship.
- *Life-course*: where the therapy fits within processes that occur over the person's life as a whole.

Each of these units can be regarded as representing a different way of 'seeing' what takes place in therapy. Analysing microprocesses within speaking turns is like looking at therapy through a microscope. By contrast, examining the process of a whole treatment, or where the treatment sits within a person's life as a whole, is like constructing a map by using a telescope or drone to view the furthest horizons. The examples of therapy process discussed in this book reflect what can be found in the therapy literature, which mainly comprise investigations of microprocesses, events, phases (particularly the start and finish of therapy), and process links across treatment as a whole (e.g. a strong working alliance established early in therapy is associated with a better outcome at the end).

## Conversation as the core process of therapy

Conversation represents the core process in counselling and psychotherapy. Whatever happens in therapy is grounded in the conversation between client (or clients) and therapist. For example, even if physical activities such as meditation, a relaxation exercise, dance, or music-making are



undertaken, these activities are introduced in a conversation, and then their meaning is explored in a further conversation. However, such non-verbal episodes are relatively rare in therapy – most of the time therapy comprises just talking. Thus understanding the process of therapy requires an appreciation of the kinds of processes that occur in conversations.

Conversational processes that are highly significant in relation to the work of therapy include:

- *Turn-taking.* The way in which one speaker gives way to the other is an expression of how collaboration is managed in a relationship. For example, one person may not leave spaces for the other to join in, the listener may struggle to find a way to join in, or one person may talk over another. In therapy, little productive work can take place unless a rhythm of turn-taking is established. Awkwardness in turn-taking may have parallels in similar difficulties in the everyday life of the client or therapist.
- *Positioning.* When someone talks, they position both self and the other in some way, for example as weak or powerful, interesting or boring, morally good or bad, and so on (Winslade 2005). The process of positioning can be seen as an invitation to the other person to accept the positions that are on offer. Subject positions always refer to a broader cultural discourse. For example, in therapy, clients typically position themselves as powerless and troubled, and accomplish this by drawing on a discourse of mental illness through the use of certain words, phrases, and ways of talking. Ultimately, the purpose of therapy is to achieve a reformulation (new way of talking) through which the client positions themselves as powerful, resourceful, and agentic.
- *Metacommunication.* This process refers to the ability to stand back from the flow of conversation and comment on what has been happening. For example, a client may tell their therapist, 'I don't think you really heard what I tried to say just now', or a therapist might say to the client, 'I was aware that when you started talking about how depressed you were, you started looking out of the window'.
- *Dialogue.* Dialogue occurs when each speaker expresses their own beliefs, values, and experiences, while at the same time being open to, and acknowledging, the beliefs, values, and experiences of the other. This can lead to the emergence of new ways of understanding that build on, but go beyond, the pre-existing ways of making sense of each participant.

These conversational processes – turn-taking, positioning, metacommunication, and dialogue – constitute the ways in which both personal identity, and relationships, are constructed on a moment-by-moment basis. And many other therapeutically relevant aspects of conversation take place in and around these processes, such as silence, voice quality, use of metaphor, word choice, control of topic, and so on. When reflecting on and trying to make sense of some aspect of the process of therapy, it is useful to start by examining exactly what was said in a session, by listening to a recording or reading a session transcript. Examples of how conversational analysis has been used to explore different types of therapy process can be found in Borca and Rober (2016), Davis (1986), Kurri and Wahlström (2007), Peräkylä et al. (2008), and Strong and Pyle (2009).

### Box 4.1: Talking about process can be helpful

Being able to make sense of the process of therapy is not merely knowledge that is professionally useful for therapists, for example in relation to training and clinical supervision. Metacommunication (which, as mentioned in Chapter 3, involves using time in a session to talk about and reflect on the process of therapy) is regarded as valuable in many approaches to therapy (Kivlighan 2014) and lies at the heart of the use of feedback measures. Clients also find it helpful to talk about more long-term processes in their lives, such as causal sequences through which their problems have developed (Larkings et al. 2017).



## Starting therapy: practical issues

It makes sense to divide therapy into three broad phases: ‘beginning’, ‘middle’, and ‘end’ (Mearns and Thorne 2013). The opening phases of therapy can be split into further sets of discrete component elements, such as negotiating expectations, assessment of suitability for counselling, the formation of a therapeutic relationship, agreeing a contract, helping the client to tell their story, and so on. The distinctive tasks of early sessions of therapy are to establish a way of working together (including arriving at a decision on whether this is possible) and identifying the goals of therapy.

The remainder of this chapter explores the main issues that arise during early sessions. It is important to keep in mind that the beginning of therapy cannot be regarded as comprising a clearly defined block of time. Processes and tasks associated with the start of therapy may re-emerge later in therapy: the therapy contract or relationship may need to be reviewed or re-negotiated. In addition, it needs to be acknowledged that the process of starting therapy begins long before the person actually makes an appointment with a therapist. For example, the decision to enter therapy is influenced by the help-seeking behaviour of the individual, their attitudes to mental health issues, the availability of therapy within their community, and many other factors.

### Informed consent

Therapy is a professional relationship. A therapist is part of a professional network that carries certain rights and privileges that stretch beyond the immediate face-to-face meeting with a client. For example, a therapist takes notes, uses clinical supervision and consultation, and has a duty to take action in response to information disclosed by the client regarding risk of harm to self or others. A therapist also possesses knowledge about the effectiveness and limitations of the therapy approach that they use, and the availability and effectiveness of other approaches that might be valuable to the client. The therapist also operates within a set of administrative procedures regarding fees and arrangements around missed appointments or therapist impairment, and client complaints. The client needs to be informed about these issues and provided with an opportunity to ask questions, and there needs to be some possibility for client needs and preferences to be taken into account. This aspect of the start of therapy presents considerable challenges to therapists (O'Neill 1998). There is potentially a lot of information to convey, the client may be emotionally needy and not in a good state of mind to take it all in, and there are some scenarios that only really make sense to a client once they have experienced them. Good practice can involve providing the client with written information, and checking out their understanding of ethical issues at later points in therapy.

### Negotiating expectations and preferences

A person who attends therapy is likely to have an understanding of what happens in therapy, even if they are not consciously aware of how much they know. Sources of information about therapy include books, cartoons, movies, websites, and listening to the experiences of friends and family who have undergone therapy. There are two aspects of client knowledge of therapy that are particularly significant in relation to the start of therapy: expectations and preferences.

Client *expectations* relate to the images or beliefs that clients hold about what will happen in therapy. This is a topic that has been investigated extensively by therapy researchers over many years (Bragesjo et al. 2004; Galassi et al. 1992; Greenberg et al. 2006; Pistrang and Barker 1992; Rokke et al. 1990; Shapiro 1981; Wanigaratne and Barker 1995). There are several general dimensions of client expectation: beliefs around the helpfulness and length of therapy; credibility of specific therapy approaches (e.g. psychodynamic or CBT); therapist style (e.g. directive vs. non-directive); and client role. There is evidence that clients who receive a form of therapy that matches their expectations are more likely to do well, particularly in time-limited therapy (Hardy et al. 1995; Morrison and Shapiro 1987). However, in one study, clients whose expectations were disconfirmed by their experience of therapy (in the sense of being pleasantly surprised) did better than those

whose expectations were confirmed (Westra et al. 2010). The key tasks around expectations is to find out what they are, provide information that offers the client a realistic set of expectations, and explore the ways in which the client's expectations might have an impact on their engagement in therapy.

Client *preferences* relate to activities and procedures that the client believes are likely to be helpful for them, personally. These are things that the client wants to happen in therapy, and is willing to commit to if they are offered. Although there is an overlap between expectations and preferences, the concept of preference is much more closely aligned to choices around what will work in therapy for a particular client. There has been a great deal of research into client preferences in recent years (Lindhiem et al. 2015; McLeod 2012, 2013b; Swift and Callahan 2009; Swift et al. 2013). This research has established that fulfilment of client preferences has an enormous influence on whether a client achieves a good outcome. Preference fulfilment is a stronger predictor of therapeutic success than is the type of therapy (e.g. psychodynamic and CBT) that is offered, even when that therapy has been shown to be effective for the specific problem reported by the client.

Client preferences are multi-faceted. Clients have preferences for particular therapy models, but also for specific interventions (Berg et al. 2008), therapist responses (Cooper and Norcross 2016), and values. Liddle (1997) found that many gay and lesbian clients put a great deal of time and effort into finding an 'affirmative' counsellor or therapist. Clients may also express preferences for the gender, age, and ethnicity of their therapist, and the scheduling of sessions. Preference may encompass therapy modality – group, couple, on-line, outdoor – and use of medication. Clients also have negative preferences – ideas about what will not help (Walls et al. 2016).

Many strategies exist for finding out about client preferences, and using this information to shape the therapy experience offered to clients (Tompkins et al. 2013). The client can be asked about their preferences, possibly using an interview guide. There are also brief preference questionnaire measures that can be used. Clients can be encouraged to identify their ideas about what would be helpful at any point as therapy unfolds, for example in progress reviews or following the use of a particular intervention or activity.

The importance of client expectations and preferences is often underestimated by therapists. The setting for therapy – the agency and the therapy room – is familiar to the therapist. The therapist is also thoroughly acquainted with the 'rules' of therapy and how it works. Furthermore, most clients will regard therapists as high-status 'experts' who can be trusted to guide them in the direction of what is best for them. For all these reasons, clients are likely to be dominated by the therapy situation, and find it hard to articulate their assumptions and wishes about what should happen. Often, the mismatch between client and therapist assumptions only comes to light when a client fails to turn up for a session (see Chapter 6). Around one in three therapy contacts ends in this manner. In some of these cases, the client may well be satisfied with what they received; in other cases, however, they may well have been dissatisfied.

## Preparation for therapy

The realisation that many potential clients may not understand the way that therapy operates has led some practitioners to develop and evaluate methods of providing appropriate pre-therapy information, such as role induction videos or leaflets. For example, Reis and Brown (2006) showed clients a brief (12-minute) video presentation on what therapy is, and how one can benefit from it, and found that premature drop-out was reduced significantly. However, Strassle et al. (2011) found that a similar video preparation technique had no effect. There has been relatively little research or innovation recently around the preparation of clients for therapy. Beutler and Clarkin (1990) offer an excellent analysis of the first wave of work on client preparation techniques; subsequent developments are discussed in Strassle et al. (2011). It is possible that the expansion in sources of information about therapy, such as books and websites, and the fact that a substantial proportion of the population has received therapy, has reduced the need for such initiatives.

## Assessment

The beginning of therapy involves a process of *assessment*. Many therapists and therapy agencies explicitly demarcate assessment or ‘reception’ sessions as separate from actual therapy, possibly carried out by someone other than the therapist the client eventually sees. Assessment can serve a wide variety of purposes (see Table 4.2), including evaluating whether the person will benefit from the therapy that is available, helping the client to make up their mind about whether or not to commit to therapy, and agreeing times, scheduling, and costs. Some therapists employ standardised psychological tests as part of the assessment phase (Anastasi 1992; Watkins and Campbell 1990; Whiston 2000). These tests can be utilised to evaluate a wide range of psychological variables, such as anxiety, depression, social support, and interpersonal functioning. Others use open-ended questionnaires that the person completes in advance of the assessment interview (Aveline 1995; Mace 1995a).

The nature of assessment depends a great deal on the theoretical model being used by the therapist or therapy agency: a wide spectrum of assessment practices can be found (Mace 1995b; Palmer and McMahon 1997). On the whole, psychodynamic counsellors and psychotherapists consider it essential to carry out an in-depth assessment of the client’s capacity to engage with unconscious or hidden dimensions of their life experience. For example, Hinshelwood (1991) proposes that a psychodynamic assessment should explore not only the current life situation of the client, but also object-relations in early life, and the transference relationship with the assessor. Hinshelwood also suggests that other useful information that can be collected includes the assessor’s countertransference reaction to the client and the client’s ability to cope with a ‘trial interpretation’ of some of the material that is uncovered. Coltart (1988) regards ‘psychological mindedness’ as a crucial criterion for entry into a long-term psychodynamic therapy.

**Table 4.2:** Reasons for making a formal pre-therapy assessment

Establishing rapport	Providing the client an opportunity to ask questions
Making a clinical diagnosis	Giving a taste of the treatment
Assessing the strengths and weaknesses of the client	Motivating the client; preventing non-attendance
Enabling the client to feel understood	Selecting clients for treatment
Providing information	Selecting treatments or a therapist for the client
Explaining the way that therapy works; obtaining informed consent	Arranging for any further assessments that might be necessary (e.g. medical)
Gathering information about cultural needs and expectations	Giving the client a basis for choice of whether to enter counselling
Arriving at a case formulation or plan	Making practical arrangements (time, place, access)
Giving hope	Providing data for research or audit

### Box 4.2: Psychological mindedness: an indicator of readiness to engage in therapy

Some therapists and counsellors believe that it is difficult, or even impossible, to work effectively with clients who lack a capacity or willingness to make sense of their actions in psychological terms. The construct of *psychological mindedness* has been used as a means of measuring this capacity. Appelbaum (1973: 36) has defined psychological mindedness as ‘a person’s ability to

see relationships among thoughts, feelings and actions, with the goal of learning the meaning of . . . experiences and behaviour'. When carrying out assessment or intake interviews, it can be useful to direct attention to the level of psychological mindedness of a client. A number of assessment tools have also been developed to evaluate the client's level of psychological mindedness (Conte and Ratto 1997). For example, the *insight test* (Tolor and Reznikoff 1960) presents the client with a series of hypothetical situations and then asks them to choose between a set of four possible explanations for the situation. An example of an item from this technique is:

A man who intensely dislikes a fellow worker goes out of his way to speak well of him.

- 1 The man doesn't really dislike his co-worker.
- 2 The man believes he will make a better impression on others by speaking well of him.
- 3 The man is overdoing his praise in order to cover up for his real feelings of dislike.
- 4 The man doesn't want to hurt anyone's feelings.

The third response represents the most insightful (or psychologically minded) response, whereas the first item represents the least insightful explanation. Alternatively, McCallum and Piper (1997) have constructed a psychological mindedness assessment procedure that does not provide answers to the client, but instead requires them to give their own personal response. Clients are asked to watch two scenarios on video, and then asked to explain in their own words why they think the people they have observed were behaving in the way they were.

Behaviourally oriented therapists regard assessment as necessary in order to identify realistic, achievable treatment goals (see Chapter 8). By contrast, humanistic, experiential, and person-centred therapists tend to eschew formal assessment on the grounds that they do not wish to label the client or to present themselves in an 'expert' position (see Chapter 10). Some humanistically oriented counsellors may employ 'qualitative' methods of assessment, where the client will be invited to participate in learning/assessment exercises integrated into the flow of the therapy session itself.

A central aim in assessment is for the therapist to feel confident that they have the potential to help a client. Halgin and Caron (1991) suggest a set of key questions that counsellors and psychotherapists should ask themselves when considering whether to accept or refer a prospective client:

- Does the person need therapy?
- Do I know the person?
- Am I competent to treat this client?
- What is my personal reaction to the client?
- Am I emotionally capable of treating the client?
- Does the client feel comfortable with me?
- Can the client afford treatment under my care?

There are times when the outcome of an assessment interview will be that the client is referred to another agency. This process can be hard to handle, and evoke powerful feelings in both clients and assessors (Iarussi and Shaw 2016; Marmarosh et al. 2017; Wood and Wood 1990).

A theme that emerges most clearly from research into the impact of assessment on subsequent therapy, is that a collaborative approach to assessment can have a significant impact on the quality of the client-therapist relationship, and the client's engagement in the therapy process (Finn and Tonsager 1997; Fischer 2000; Hilsenroth and Cromer 2007). In a qualitative study of the experience of assessment in adolescent clients, Binder et al. (2013) found that clients described a tension between

the risk of their therapist losing contact with their unique qualities and strengths, and the assessment providing hope through the client's trust in the competence of the therapist. This tension could be resolved if the therapist appeared to be genuine, acted in a collaborative way, and was carrying out the assessment in the interests of the client rather than merely following organisational procedures.

Therapist activities during assessment that Hilsenroth and Cromer (2007) identified as being positively related to the establishment of a strong therapeutic alliance include:

- conducting longer, depth-oriented assessment interviews;
- adopting a collaborative stance towards the client;
- using clear, concrete, 'experience-near' language;
- allowing the client to initiate discussion of salient issues, and actively exploring these issues;
- clarifying sources of distress;
- facilitating client exploration of feelings;
- reviewing and exploring the meaning of assessment results (e.g. questionnaire scores);
- providing the client with new understanding and insight;
- offering psycho-educational explanations around symptoms and the treatment process;
- collaboratively developing therapy goals and a treatment plan.

Hilsenroth and Cromer (2007) point out that these activities and principles transcend any particular theoretical approach, and can be readily adopted within most therapy settings.

In conclusion, it can be seen that there are many choice points available to therapists around how to conduct assessments. In many circumstances, practical factors (e.g. time constraints) may influence and limit the type of assessment that can be carried out. However, there is strong evidence to suggest that carefully designed assessment, appropriate to the model of therapy that is being provided, can do a great deal to prepare both client and therapist to work together in an effective manner.

### Box 4.3: Clients assess their therapists

In an interview study of the experiences of African American working-class clients attending therapy in a community mental health centre in the USA, Ward (2005) found that all the clients who were interviewed described themselves as actively assessing their therapist during initial meetings. Clients reported that their assessment covered three main areas: how effective the therapist appeared to be, how safe they felt with the therapist, and the degree of client–therapist match. It is possible that in this particular context, in which many clients may distrust the involvement of the courts in their therapy or may have had damaging experiences with previous therapists, is one in which the process of client appraisal of their therapist is particularly salient. Nevertheless, the findings of this study do seem to capture something of the essence of the early meetings that any client has with their therapist.

## Diagnosis

There is considerable controversy around whether it is helpful for counsellors and psychotherapists to make a diagnosis of their clients' psychopathology. Within most healthcare systems, patient statistics and therapy protocols tend to be organised around diagnostic categories. Two diagnostic

systems are currently in use: the International Classification of Diseases (ICD) diagnostic guide, published by the World Health Organization, is widely employed in Europe and many other countries; the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association, is used exclusively in North America, and has also been adopted elsewhere. There are many similarities between the two systems. DSM-5 (the most recent edition of the manual) was published in 2015. Further information on DSM-5 can be obtained through a wide range of readily available books and websites. The factors in favour of using diagnosis include the following:

- Some clients find it reassuring to be able to categorise and make sense of their problems, and realise that their difficulties are not unique.
- A diagnosis can give access to welfare benefits, other forms of statutory support, and self-help networks.
- Therapists working in medical settings are able to communicate effectively with colleagues in other healthcare disciplines.
- A diagnosis provides access to treatment manuals that are structured in terms of diagnostic classifications, such as depression, anxiety, and borderline personality disorder.
- In some environments (e.g. managed care services in the USA), a diagnosis is a necessary precondition for being accepted for treatment.
- A diagnosis helps practitioners to be clear about the limits of their competence (for example, in identifying cases where clients may require specialist referral).

There are also strong arguments against the use of diagnosis in counselling and psychotherapy (Davies 2014; Frances 2013; Greenberg 2013; Johnstone 2013; Johnstone and Boyle 2018):

- There is a danger of labelling patients in ways that could negatively impact on future employment prospects.
- There is little evidence that diagnostic information is of any use in planning or choosing the right therapy for any individual client.
- Psychiatric categories are not scientifically valid, in the sense of offering a reliable and valid set of concepts that reflect the realities of people's lives.
- Diagnostic procedures introduce an expert-dominated relationship that can undermine collaborative work between client and therapist.
- Defining the problem as an 'illness' may make it harder for the client to commit themselves to a therapy, which always requires active participation and taking responsibility for personal change.
- The use of diagnosis introduces a medical/biological perspective that is not consistent with the aims and processes of therapy.

Many critics of psychiatric diagnosis also draw attention to the ways in which the development of diagnostic systems is controlled by 'big pharma', and as a result is oriented towards social control and profit rather than the well-being of service users (Cosgrove and Wheeler 2013; Whitaker and Cosgrove 2015).

The debate around the use of diagnosis is multi-faceted, with strong arguments for both positions. In pragmatic terms, much therapy takes place in settings where clients attend for fewer than six sessions, and where formal diagnosis (which usually requires a whole session) would constitute a waste of precious therapeutic time. In other settings, where counselling is delivered by volunteers or paraprofessionals, it would not be realistic to expect the counsellor to be a competent diagnostician. However, therapists who lack information about diagnostic systems run the risk of cutting themselves off from the huge resources and accumulated knowledge of the therapies used in the medical domain.



### Box 4.4: Alternatives to psychiatric diagnosis

Dissatisfaction with psychiatric diagnosis, accompanied by recognition that some kind of classificatory model is necessary, has motivated therapists to arrive at alternative diagnostic approaches. The ‘personality adaptations’ model developed by Joines and Stewart (2002) has been adopted by many therapists, and comprises a reframing of psychiatric categories that is more closely aligned with the goals of therapy and, notably, emphasises the positive (adaptive) function of what might otherwise be viewed as merely dysfunctional patterns of behaving. A more radical approach is represented by the Power Threat Meaning framework, developed by a group of clinical psychologists in the UK (Johnstone and Boyle 2018). This model argues for the replacement of psychiatric diagnosis by individual case formulation, based on assessment of how the person responds to social adversity in their life.

### Agreeing goals

There is much evidence that clarity around the goals of therapy, and some agreement between client and therapist regarding goals, are associated with good outcomes in therapy (Law and Cooper 2017; Michalak and Holtforth 2006; Tryon and Winograd 2001). By contrast, failure to be clear about goals can lead to a therapy that lacks focus, or unhelpful divergence between therapist and client around what they think they are trying to achieve. Although the client’s goal or wish for therapy is typically expressed within the first two or three minutes of the first meeting, it can take time to articulate goals in a form that provides a framework for collaboration in therapy. Clients may have conflicting goals, or find it hard to identify constructive and achievable approach goals (‘I want to be comfortable when talking to other people in social situations’) rather than vague avoidance goals (‘I just want these scary feelings to stop’) (Law and Jacob 2013). Exploring goals involves more than just being clear about the aims and purpose of therapy. Mackrill (2010) argues that talking about goals can open up significant existential issues around the person’s capacity to acknowledge a sense of a personal future, whether the person is able to make choices and exert control over their life, and how they define the meaning of their life. In some cases, important goals may be out of conscious awareness, and expressed in actions rather than words (Bugas and Silberschatz 2000). For example, although they could not or might not admit it, a person may have an unconscious goal of being fully accepted in a relationship. This goal might emerge through constant testing of their therapist’s willingness to accept challenging behaviour such as being late for sessions. In such a situation, being able to arrive at a point where the goal could be stated in words could represent a considerable achievement on the part of the client.

Some therapists use goal rating forms to make sure that there is a concrete agreement on goals, and to be able to monitor progress over time in the direction of goal attainment (Law and Cooper 2017; Law and Jacob 2013). Other therapists, mindful of the subtle and complex nature of client goals, use a range of strategies for making sure that goals are mutually understood, but without ever defining them in a particular phrase or statement (Oddli and Rønnestad 2012).

### Case formulation and contracting

Having carried out some kind of initial assessment of the problems for which the client is seeking help, and their goals for therapy, the next stage of the therapy process usually involves the construction of some kind of *case formulation*. A case formulation can be viewed as an overall framework that can be used to guide the activities of the client and therapist. A typical case formulation might include the following elements:

- 1 Current issues/presenting problems/stated goals.
- 2 Underlying causes/vulnerability – Why does the person have these problems?



- 3 What are the mechanisms/actions/processes through which these difficulties are maintained? Why haven't they disappeared by now? Why hasn't the person been able to deal with these problems already? How do these mechanisms connect the underlying and the current problems?
- 4 Why now? What has precipitated the need for help now?
- 5 How can the problem be tackled in therapy? (treatment plan)
- 6 What are the obstacles to therapy? What are the client's strengths?

Different therapy approaches attach differing degrees of importance to the role of case formulation.

Practitioners also differ in the extent to which they explicitly share their formulation with the client. Some therapists, for example in cognitive analytic therapy (Ryle 2005; Ryle and Kerr 2002), will provide the client with a written statement and diagram outlining the formulation in some detail. Other therapists might merely introduce aspects of the formulation into the therapy conversation at appropriate moments. In pluralistic therapy (Chapter 21) and some forms of CBT (Chapter 8), an explicitly collaborative approach to case formulation is used. Further information on the variety of strategies for carrying out and using case formulations can be found in Eells (2007) and Johnstone and Dallos (2014).

Tracey Eells and his colleagues have carried out a series of studies into therapist competence in case formulation (Eells and Lombart 2003; Eells et al. 2005; Kendjelic and Eells 2007). This research programme has shown that there are marked differences in formulation quality associated with levels of experience. Compared with more experienced colleagues, novice therapists produce formulations that are less detailed and coherent, and which do not clearly specify the causal factors or mechanisms that link underlying conflicts with current presenting problems. This research also showed that brief training in the principles of case formulation could produce major shifts in competence (Kendjelic and Eells 2007).

Studies have been carried out in which clients have been interviewed about their experience of case formulation (Kahlon et al. 2014; Redhead et al. 2015). Clients in these studies described a number of helpful processes that were facilitated by the formulation episode: they gained a better understanding of their problems, they felt understood and accepted by their therapist, they were aware of an emotional shift in themselves that enabled them to move on and encouraged them to talk more fully. Formulation was favourably contrasted with experiences of therapy in which such an activity had not been on offer. As well as these helpful processes, some clients also reported that it had been distressing to be so clearly faced with their difficulties, and that it was hard to know how to respond when they perceived aspects of the formulation to be inaccurate.

Formulating an understanding of a case, and developing a sense of where the therapy might go, is associated with the use of *contracting*. As with case formulation, there are major differences between therapists trained in different orientations, in relation to their use of contracting. Some therapists generate written contracts that their clients are asked to sign, whereas other therapists merely rely on a verbal agreement to work together. An aspect of contracting that many therapists find useful is 'no suicide' contracting (which can also be applied to other risk situations), comprising an agreement around what the client will do if they are contemplating ending their life (White 2010). A valuable introduction to the issues involved in making a contract with a client, and practical strategies for facilitating the process of contracting, is available in Sills (2006).

## Introducing feedback measures

Increasingly, therapists invite clients to complete brief measures of symptom and goal change, and the therapeutic relationship, at each session. The rationale for this procedure, and the nature of the practical arrangements around where and when the scales will be filled in, who will see them, etc., need to be introduced during an assessment meeting, or at the first therapy session. Further discussion of the use of client feedback is provided in Chapter 5.

### Box 4.5: Making sure there is enough time to get off to the best possible start

The beginning stage of therapy typically involves attending to a range of matters that need to be addressed in order to allow therapy to proceed in an ethical and professionally appropriate manner. Alongside these structural aspects (creating a structure within which therapy can take place), there is also the requirement to give enough space for the client to tell their story, and possibly also to gain some emotional relief. It is hard to achieve all of these tasks within a one-hour session. As a result, some models of therapy, such as psychodynamic-interpersonal therapy (Barkham et al. 2017; see also Chapter 7), offer an initial meeting that can be as long as three hours. An extended session is a signal that the client's needs are being taken seriously and makes it possible for the client to begin to develop trust and confidence in the therapist.

## Starting therapy: the interpersonal process

The process of starting therapy does not merely consist of the completion of a series of tasks such as informed consent, assessment, and case formulation. It also represents a period of time when two (or more) people are meeting each other, getting to know each other, and are trying to establish a way of being and working together. This interpersonal process has been explored in qualitative research studies that have involved interviewing clients and therapists around their experience of early sessions of therapy. A review of such studies (Lavik et al. 2018) found that when clients were asked to reflect on their experience of early sessions of therapy, they emphasised the importance of being helped to deal with their fear and apprehensions around starting therapy. The aspects of therapy that were particularly valuable in enabling them to do this were having a sense of their therapist as being warm and competent, being understood as a whole person, and feeling appreciated, tolerated, and supported. If these elements were in place, they reported that gaining new strength and feeling hopeful for the future. Similar themes emerged in studies that had analysed therapist experiences of early sessions (Lavik et al. 2018). The therapists in these studies talked about the importance of ensuring that the client felt safe. Beyond that, they described how they also sought to convey warmth, show a genuine desire to understand the client, pay attention to body language, and provide helpful experiences. The therapists stated an overall aim of striving to support client agency, through drawing attention to the capacity of the client to make choices.

The significance of dealing with apprehensions and creating safety, in both client and therapist accounts of their experiences in early sessions, reflects the salience at the start of therapy of assessment, contracting, and consent tasks discussed earlier in this chapter. The themes that touch on issues of client agency and hope are relevant to core issues around what leads a person to want to enter therapy.

In his classic analysis of emotional healing in different cultures, Frank (1974; Frank and Frank 1993) suggested that a sense of 'demoralisation' was a common factor in the decision to seek specialist or professional help. Frank found that faced with a problem in living, a person made their best effort to address their difficulties using their own resources and the help of their family and members of the community. It is only when these efforts proved insufficient that they turned to a therapist (or equivalent in other cultures). At that point, their emotional and psychological state could be characterised as being low in both agency (being able to make things happen) and hope (the sense that a better future is possible).

'Instillation of hope' is widely regarded as a therapist activity that is crucial at the start of therapy (Frank 1974; Frank and Frank 1993; O'Hara 2013). Research studies that have looked closely at what happens in early sessions have found that therapists engage in a myriad of hope-inducing

activities, and that clients are aware of this – and find it helpful (Larsen and Stege 2010a, 2010b, 2012; Sælør et al. 2015). The promotion of hopefulness occurs in many small but significant ways, such as reframing, using humour, using the word hope, using examples from their own lives, acknowledging lack of hope, and drawing attention to client resources (Larsen and Stege 2010a, 2010b). These activities position the therapist as the ‘holder of hope’: one who believes that the client will eventually be able to have a better life. The social influence of the therapist, as a respected figure, has the effect of encouraging the client to begin to talk in more positive ways, and gradually to begin to view their problems as solvable rather than intractable. This is particularly essential at the start of therapy, because the actual work of change will almost certainly require the client to face up to thoughts, emotions, and experiences that they had hitherto been avoiding (Hanna and Puhakka 1991). It is therefore important that the client has hope that painful or embarrassing therapeutic activities will eventually be worthwhile.

Alongside building hope, another shift that a therapist tries to facilitate in early sessions is movement in the direction of accepting personal agency and responsibility, rather than blaming one’s troubles on others. Research studies that have closely analysed transcripts of therapy dialogue in early sessions have discovered that this process is clearly evident. Toivonen et al. (2018) observed that clients routinely talked in ‘non-agentic’ ways. Lømo et al. (2018) found differences between clients in the types of conversational ‘gateways’ or invitations that clients extended to their therapists in early sessions. Some clients invited their therapists to join with them in exploring how the client might be able to change their way of thinking and behaving. Other clients invited their therapist to join with them in exploring how another person might change, or to talk about how unfair life had been. In the latter scenario, it was hard for the therapist ever to re-focus the conversation along more agentic lines. Oddli and Rønnestad (2012) examined the strategies used by therapists in early sessions to support client agency. They found that effective therapists were doing this most of the time. Some of the ways in which agency was supported were extremely subtle – for example, talking in a tentative manner with lots of ‘hedging’ phrases, so that the client would finish sentences and take control of word choice. Therapists also supported agency in other ways, such as by inviting the client to imagine a future, or pointing out the client’s authority and agency around choices they had made in their life as a whole, as well as choices around what would happen in the therapy session.

Qualitative studies of what happens in early sessions of therapy supply a richly detailed and nuanced appreciation of this phase of therapy. Taken as a whole, these studies provide a reminder that, in addition to technical and structural elements, the beginning of therapy is a time when each participant enters the life world of the other. Within this process, the therapist needs to achieve a balance between being both a competent professional and a warm, accepting, caring, and genuine person, and a balance between a position of listening and affirming and a position of facilitating change. After a while, these contrasting roles either get worked out in a satisfactory manner, or the client withdraws from therapy (emotionally or physically). A further insight that emerges from qualitative research is that although the client enters therapy wanting to talk about (and do something about) their depression, anxiety, loss, or other difficulties, the therapist is required not only to listen and respond to these troubles, but at the same time to try to construct way of talking about these issues (i.e. hopefully, agentially, collaboratively) that will allow productive therapeutic work to take place. Chow (2018) provides a valuable discussion of therapist strategies for effectively handling first sessions.

## Conclusions

What happens at the start of therapy is important. There is evidence that the establishment of a positive early alliance or collaborative relationship between client and therapist is associated with better outcomes (Flückiger et al. 2018). Symptom improvement in early sessions is linked to good outcome at the end of therapy (Haas et al. 2002). Failure to accommodate client preferences contributes to

clients dropping out of therapy. These findings do not mean that it is futile to persevere if therapy gets off to an awkward start. Some clients need time to learn to trust their therapist, or to come to terms with what is required in therapy. Some therapists need time to find the best way to accommodate client needs. Nevertheless, it is clear that the processes that occur at the beginning lay down a pattern that strongly influences what happens next.



### Topics for reflection and discussion

- 1 Identify a real-life (i.e. not therapy) situation in which you had a meaningful and satisfying conversation with another person. What were the conditions that made this conversation possible? What was it about the conversation that made it satisfying? What were the consequences of that meeting? Finally, what are the implications of that experience for therapy?
- 2 In your view, is systematic assessment of clients necessary or useful? What might be some of the ways in which the experience of assessment may affect clients in terms of their motivation to participate in therapy?
- 3 How might a client's expectations affect the way they behave in therapy? What can both the therapist and the client do to address conflicting expectations?

### Suggested further reading

There is little to be said about the process of therapy that has not already been said by Carl Rogers in his classic paper, 'A process conception of psychotherapy' (published in *On Becoming a Person*, 1961). There are two sources that allow therapy process research to be seen from a broader perspective. Greenberg and Pinsof (1986) is an edited collection that includes detailed accounts of most of the main approaches to process research. In a recent article, two of the key figures in process research, Donald Kiesler and Irene Elkin, look back at how this field of inquiry has evolved (Knobloch-Fedders et al. 2015). An overview of the implications for practice of an understanding of the therapy process is available in DeFife and Hilsenroth (2011). The literature on what happens at the start of therapy is discussed by Chow (2018). Valuable insights into the distinctive processes that occur in client–therapist interaction in early sessions can be found in Lavik et al. (2018) and Oddli and Rønnestad (2012).

# Chapter

# 5

## The hard work: choices, learning, and change

<b>Introduction</b>	<b>62</b>
<b>Change: gradual process or significant event?</b>	<b>63</b>
<b>Basic processes of learning and change in therapy</b>	<b>64</b>
Planned behaviour change	65
Dealing with internal conflicts	67
Openness to new experience	69
Intensity, resoluteness, and courage	70
<b>Finding what helps</b>	<b>71</b>
Micro-analysis of helpfulness	72
The client's experience of what is helpful	73
The client's experience of what is unhelpful	75
<b>Staying on track</b>	<b>76</b>
Resolving impasses	76
Using feedback	78
<b>The covert dimension of process: what is going on under the surface</b>	<b>80</b>
<b>Conclusions</b>	<b>81</b>
<b>Topics for reflection and discussion</b>	<b>82</b>
<b>Suggested further reading</b>	<b>82</b>

### Introduction

The overall process of therapy encompasses a phase at the start, where a therapeutic relationship and contract begin to be established, and a phase at the end, where therapy is brought to a close. Between these phases, and overlapping them, lies a set of processes that are often experienced by clients and therapists as 'hard work'. The aim of the present chapter is to look more closely at this stage of therapy.

Therapy is hard work because the person is typically seeking to change ways of thinking, feeling, and relating to others that are deeply ingrained in their life. In therapy, the person may need to learn about who they are and how and why they respond to specific situations in the ways that they do. They may need to make choices, and create new patterns of behaviour. These changes typically involve renegotiation with other people with whom the person shares their life. They may require readjusting the person's own sense of who they are – their personal identity. In some cases, a brief contact with a therapist can allow something new to click into place, that enables the person to address or resolve the problem that brought them to therapy. In other cases, the process of learning and change may take a long time. Many people talk about their therapy in terms of a 'journey' or a 'project'. For individuals who have been deeply damaged by trauma, abuse, or other adverse life experiences, therapy may be part of a broader process of 'rebuilding' a life.

Each of the therapy approaches or traditions introduced in later chapters (Part 2) offers its own distinctive ideas about the change processes that represent 'hard work'. The present chapter provides an integrative overview of the change process, relevant to all theoretical orientations and types of therapy.

## Change: gradual process or significant event?

There is a sense in which therapeutic processes can be viewed as inseparable, overlapping, and braided together. From this perspective, change can be viewed as a gradual unfolding of greater self-awareness, or mastery of new skills and behaviours. A 'gradualist' perspective on change can be found in the influential writings of Carl Rogers, who used the metaphor of biological growth, and the creation by the therapist of an environment within which growth can occur, as the basis for his approach to therapy. By contrast, many counsellors and psychotherapists find it helpful to look at change in terms of a series of significant events, shifts, good moments, breakthroughs, or turning points. These events can be regarded as particularly intense, meaningful, and memorable episodes within sessions. They are the moments when 'something happens'.

There is a substantial body of research that has explored different types of change event (see, for example, Greenberg et al. 1993; Mahrer et al. 1987; Present et al. 2008; Stiles et al. 2003; Tang and DeRubeis 1999; Timulak 2010). The findings of these studies support the notion that, at least some of the time, therapeutic change is associated with the occurrence of powerful in-therapy events. Supporting clinical evidence is also available in the form of observations by therapists of 'quantum change' in some clients: 'sudden, dramatic, and enduring transformations that affect a broad range of personal, cognitive and emotional functioning' (W. R. Miller 2004: 453).

However, it is also clear that valuable therapeutic work can be carried out in the absence of memorable or notable special moments or events. Overall, it seems sensible to regard therapeutic change as mainly comprised of small steps, arising from a gradual process of exploring and resolving personal issues, which may be occasionally punctuated, for some clients, with more intense events or moments in which some kind of personal revelation or transformation occurs. It is important for therapists and clients to be able both to acknowledge and celebrate these events when they occur, and not to feel disappointment if 'Hollywood moments' do not arise naturally.

To a large extent, the dichotomy between change processes and change events is a matter of the perspective from which therapy is analysed. If a client or therapist describes a significant, life-changing moment in therapy, further analysis always reveals that the transformative moment in question was only made possible by a preceding ongoing set of facilitative and enabling processes. Conversely, if a gradual process of change ('the acceptance I felt from my therapist just made me feel more and more confident in my own abilities, week by week') is subjected to micro-analysis in which moment-by-moment client-therapist interactions are examined, it usually becomes apparent that some interactions stand out as different and significant, and appear to lead to different ways of



responding on the part of the client. A comprehensive analysis of how therapy works needs to take account of both gradual change and significant events.

## Basic processes of learning and change in therapy

In practice, therapists enable and facilitate the process of change using a wide range of skills, strategies, and techniques (see Chapter 2). These activities and resources can be viewed as contributing to the accomplishment of a set of generic therapeutic tasks and change processes. The idea that therapy consists of a definable set of general facilitative experiences, common to all forms of treatment, has been widely accepted within the counselling and psychotherapy professions for many decades (Frank 1993; Goldfried 1980; Oddli et al. 2016). It is also clear that although these change principles are given a particular emphasis in therapy, they represent facets of human experience that can also be observed in many areas of social interaction and everyday life (Lampropoulos 2001).

Different theorists and researchers have generated different lists of underlying therapy change processes or principles. For example, McLeod and McLeod (2011) have identified a set of generic tasks that clients are looking to fulfil in therapy:

- making meaning: talking through an issue in order to understand things better;
- making sense of a specific problematic experience;
- problem-solving, planning, and decision-making;
- changing behaviour;
- negotiating a life transition or developmental crisis;
- dealing with difficult feelings and emotions;
- finding, analysing, and acting on information;
- undoing self-criticism and enhancing self-care;
- dealing with difficult or painful relationships.

It is possible to condense this list even further, to key dimensions of psychological functioning: cognitive, emotional, behavioural, and social/interpersonal. From a client perspective, additional ways of making sense of core therapeutic change processes can be identified (Bury et al. 2007; Göstas et al. 2013; Perren et al. 2009). In a review of studies of how clients experience therapy, Levitt et al. (2016) noted three main dimensions of change from a client point of view: (1) becoming more curious and deeply engaged in making sense of one's life, (2) becoming more able to internalise positive messages, and (3) becoming more agentic, purposeful, and in control of one's life.

At the present time, there is no consensus within the counselling and psychotherapy literature around a definitive taxonomy of change processes. Rather than seeking to cover all possible change processes, the following sections highlight three key dimensions of 'hard work' in therapy: engaging in planned behaviour change; coming to terms with inner conflicts; generating an openness to new experiences. These change processes reflect typical therapy goals identified by clients:

- *Behaviour change*: 'I want to stop drinking or my wife will leave me'; 'I need to be able to stop feeling so anxious when making presentations at college'; 'After my heart attack, it is crucial that I have a more healthful lifestyle'.
- *Inner conflict*: 'I don't know whether to stay in my marriage or leave'; 'I can't decide on which course to take when I leave school'; 'I have a critical voice in my head that tells me I am useless'.
- *New experiences*: 'Nothing seems to mean anything any more'; 'I don't seem to feel anything inside'; 'I want to understand why I get so depressed'.



For someone seeking help through therapy, one of these change processes may represent the main focus of the work they do with their therapist. Alternatively, the person may shift back and forward across different domains. For example, working on behaviour change ('I want to stop drinking or my wife will leave me') may open up an awareness of an inner conflict ('There is part of me that is a rebellious adolescent, and another part that is a responsible adult and parent') and the importance of a search for new perspectives ('My therapist fed back to me that I avoid telling her directly what I feel').

## Planned behaviour change

Planned behaviour change is the single most common starting point for therapy: people who enter therapy almost always identify goals that involve some kind of behaviour change. The person may want to become able to socialise and make friends, or to give up alcohol or gambling, or to control their anger. If 'behaviour' is defined in a broad sense as referring to patterns of action (including internal patterns such as thinking and feeling as well as externally observable patterns such as binge eating), then behaviour change represents a core aspect of therapy. 'Planned' behaviour change consists of therapeutic work that is explicitly intended by the client, as opposed to types of change that are an unexpected by-product of participation in therapy (e.g. 'I went to therapy to deal with my depression, and was surprised to find that it also made me much better at listening to the needs of my customers in the company I work for').

Behaviour change is hard work because if the behaviour was easy to change, the person would have been able to do it without the help of a therapist. It is also hard work because once established, a habitual way of responding to situations is likely to be rewarding ('I need that drink to relax when I come home from work'). The pattern of behaviour may also represent a means of avoiding situations that are anxiety-provoking for the person ('I go for a drink after work because I can't say no to my boss'). Problematic patterns of behaviour are also typically embedded within a wider set of responses and habits ('My social life would disappear if I couldn't go to the pub') that may be long-established and hard to change.

There are two broad strategies for achieving successful planned behaviour change. The first strategy, associated with behavioural and cognitive-behavioural approaches to therapy, is to start off by identifying unwanted or dysfunctional sequences of actions, generating some ideas about preferred sequences that might replace them, and then rigorously practising this new behaviour. The second strategy is to realise that there are some situations in which the dysfunctional or unwanted behaviour is not exhibited, and so work towards replicating the state of mind and set of capabilities that make such moments happen.

The first strategy is logical and linear, and as a result makes sense to most people. However, it does not take account of self-undermining tendencies and the potential for relapse. These factors reflect the fact that, for human beings, once something has been done it is never completely forgotten. So, for example, if a person has used eating to control painful emotions, that response or pattern will always remain part of their coping repertoire even after many years of healthful eating, able to be reactivated during future periods of stress.

The second strategy, which is based on accessing neglected personal strengths and capabilities, appears contradictory to some people who seek therapeutic help with the aim of accomplishing behaviour change, because the problem, as they see it, is based in a failure to do anything other than exhibit the troublesome action sequences that are causing the problem. However, it has the advantage of being consistent with many of the core ways in which therapy operates, such as entering into a helping relationship with someone (the therapist) who is affirming of one's potential strengths, and intent on finding ways to help one to be aware of one's personal agency and capacity to take charge of one's life.

There exist many sources of common-sense advice about behaviour change, as well as many self-help books and on-line resources. The actual procedures that are used in therapy for behaviour change are familiar to most people, such as avoiding situations that elicit the problem behaviour, and practising the new behaviour. Nevertheless, there are important ways in which seeing a therapist can be helpful, over and above these procedures. The structure of meeting with a therapist every week

can be valuable as a source of motivation and encouragement, and provides someone to talk to who is willing to spend time on a topic that may be tiresome for friends and family members. There are almost always emotional barriers to change – a therapist may function as a source of emotional support, or can provide a setting in which feelings can be expressed. Finally, the target behaviour is likely to have some meaning – it may be connected to one's sense of identity, or linked to significant life experiences. For example, in some social circles gambling or drinking is part of what it means to be a man, and a male client seeking to reduce or eliminate self-destructive gambling or drinking may find it helpful to be able to talk about the implications for their gender identity.

Behaviour change can also be hard work because of social and cultural factors. For example, dieting, eating junk food, gambling, drinking alcohol, out-of-control consumer spending, and other behavioural problems, exist in a cultural context in which powerful global industries spend huge amounts of money on advertising and marketing to persuade individuals to engage in actions that have the potential ultimately to be harmful for them. Other problem behaviours, such as sexual feelings towards children, sexual violence, and intimate partner violence are considered morally repugnant by most people. The forces that maintain such patterns of behaviour, or make them hard to talk honestly about, are to a large extent beyond the remit of therapy.

### Box 5.1: Client homework – a key element in behaviour change

Having a really good discussion, within a therapy session, of how and what to do differently, and how to change problematic behaviours, is of little value if the person then fails to implement any changes in their everyday life. One of the useful strategies for bridging the gap between the therapy room and real life is the practice of agreeing on homework tasks. Homework tasks can be suggested or devised by the person or by the therapist, and can range from quite structured and formal tasks, such as writing a journal or completing worksheets, to more informal or flexible tasks, such as 'listening to other people more', 'practising slow and deep breathing as a way of coping with my anxiety', or 'visiting my grandmother's grave'. There is strong evidence that homework is a valuable aspect of therapy (Kazantzis and L'Abate 2007; Kazantzis et al. 2010). A lot of research has been carried out into the process of agreeing homework tasks in therapy (Mahrer et al. 1994; Scheel et al. 1999, 2004). Although homework is often considered a method that is primarily employed by cognitive-behavioural therapists, there is plenty of evidence that most therapists use homework with the majority of their clients (Ronan and Kazantzis 2006).

Based on a review of the research evidence, Scheel et al. (2004) have developed some useful guidelines for using homework in therapy. These include:

- basing the homework assignment on collaboration between therapist and client;
- describing the task in detail;
- providing a rationale for why the task will benefit the person;
- matching the task to the person's ability;
- writing down the task;
- asking how confident the person is about fulfilling the task, and if necessary modifying the task accordingly;
- trying out the task during the session;
- at the next meeting, asking about how the person got on with the task; and
- celebrating or praising the person's achievement of the task.

## Dealing with internal conflicts

One of the most significant processes of therapeutic change centres on resolving internal conflicts, and achieving integration between different parts of the self. This process represents a dimension of personhood that is particularly salient within modern culture: a growing sense of personal multiplicity or fragmentation. It seems that whereas in traditional cultures people were able largely just to be themselves, in modern cultures people find themselves functioning in different social roles, in different settings, with different networks of other people. Modern culture presents the individual with a substantial range of choices around identity, career, lifestyle, and location, which can result in internal conflict in the form of self-questioning, self-criticism, and decisional paralysis.

In evolutionary terms, the development of language allowed human beings to have the potential for self-reflection, since language allows the possibility of referring to self as an object as well as an active subject, enabling dialectical talk ('on the one hand . . . , on the other hand . . .'). It is likely, therefore, that a sense of self-multiplicity has always been an aspect of being human (see, for example, the powerful inner conflicts exhibited by tragic figures in Shakespearean drama). However, the conditions of modern life have contributed massively to a splitting of the experience of being who one is. The publication in 1885 of the short story 'The Strange Case of Dr Jekyll and Mr Hyde', by Robert Louis Stephenson, which enjoyed both immediate and enduring popularity, has been regarded by some cultural historians as representing a marker of the appearance of self-multiplicity as a core psychological issue.

The issue of how to make sense of inner conflict and self-multiplicity is addressed in all approaches to therapy. For example, the Jungian idea of individuation, or the idea of a 'real' or 'core' self that occurs in some humanistic theories, reflects a sense of personal wholeness as a quest. Other therapy theories, by contrast, take the notion of a fragmented self as their starting point – for example, the ego state structure used in transactional analysis (TA) (parent, adult, and child), or the idea of configurations of self in contemporary person-centred theory. Psychoanalytic theory is another highly influential and valuable framework for thinking about the dynamics of self-fragmentation (e.g. ego, id, superego). In cognitive-behavioural and other approaches to therapy, close attention is paid to the ways in which the individual may engage in harsh self-criticism or be involved in an internal battle between 'rational' and 'irrational' ways of thinking about an issue.

In therapy, evidence of unhelpful self-multiplicity can be observed through listening to how the person talks and moves within the session, or in their reports of how they behave in everyday life situations. At its most simple level, therapist awareness of client internal conflict can be used to help the client to hold a more open dialogue between parts of the self that are in tension. Another way in which internal conflict and self-multiplicity can be approached in therapy is to 'normalise' it, or consider it as an inevitable aspect of life. For example, a person who believes that there is something wrong with them if they experience different impulses to act in different ways, can be relieved to discover that self-multiplicity (e.g. 'I am angry as well as calm and kind') is just the way things are. A major theme in many approaches to therapy is the idea that self-acceptance represents a key aspect of therapeutic change.

The assimilation model, devised by Stiles and his associates (Barkham et al. 1996; Honos-Webb et al. 1998, 1999; Stiles 1991, 2001, 2002, 2005, 2006; Stiles et al. 1990, 1992), represents a framework for understanding important aspects of the change process that can occur in respect of helping a person to arrive at a productive position in relation to internal conflict. The key idea behind this model is that the individual possesses a model of the world that can be viewed as comprising a set of cognitive schemas that guide that person's behaviour. New experiences need to be assimilated into that model if they are to be understood and to make sense. This process may lead to accommodation or readjustment of the model itself. This theory is basically adopted from Piagetian developmental psychology.

The assimilation model is based on a series of stages, or a process (Table 5.1). In therapy, the most significant assimilation processes occur in relation to problematic experiences. The client reports

**Table 5.1:** Stages in the assimilation of a problematic experience in therapy

0	<i>Warded off.</i> Client is unaware of the problem; the problematic voice is silent or dissociated. Affect may be minimal, reflecting successful avoidance.
1	<i>Unwanted thoughts.</i> Client prefers not to think about the experience; topics are raised by therapist or external circumstances. Affect involves strong but unfocused negative feelings; their connection with the content may be unclear. Problematic voices emerge in response to therapist interventions or external circumstances and are suppressed or avoided.
2	<i>Vague awareness.</i> Client is aware of a problematic experience but cannot formulate the problem clearly. Affect includes acute psychological pain or panic associated with the problematic experience. Problematic voice emerges into sustained awareness.
3	<i>Problem statement/clarification.</i> Content includes a clear statement of the problem – something that could be or is being worked on. Opposing voices are differentiated and can talk about each other. Affect is negative but manageable, not panicky.
4	<i>Understanding/insight.</i> The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise of the ‘aha’ sort.
5	<i>Application/working through.</i> The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, business-like, optimistic.
6	<i>Problem solution.</i> Client achieves a successful solution for a specific problem. Voices can be used flexibly. Affect is positive, satisfied, proud of accomplishment.
7	<i>Mastery.</i> Client automatically generalises solutions. Voices are fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e. this is no longer something to get excited about).

Sources: Adapted from Barkham et al. (1996) and Stiles (2002).

an experience that is painful, or even not quite within awareness, and the task of the counsellor or therapist is to help the client to ‘take it in’ to their model of the world, to make it familiar, to become comfortable with an idea or feeling that initially was problematic. At the beginning of the process (stage 0) the problem is warded off, and the client does not report any strong emotion. However, as the problem begins to come into focus, through the emergence of unwanted thoughts (stage 1) leading to vague awareness (stage 2), the client is likely to have very strong feelings. As the process continues into clarification, insight, and working through (stages 3–6), the feelings triggered off by the problem become more manageable and less intense (stage 7).

It is important to note that not all of the problems clients work on in therapy will start at stage 0 and continue through to stage 7 in the model. A client may well enter therapy with a vague awareness of what is troubling them, or could even have arrived at a problem statement. Equally, clients may leave therapy before they have achieved mastery of the problem, either because the therapy is not long enough or because insight or even stating the problem may be sufficient for them at that point in their life. Moreover, clients may be working on two or more problematic experiences in parallel, with perhaps one of these topics as the major theme for therapy.

Examples of how the assimilation model can be applied in individual cases can be found in Brinegar et al. (2008), Goldsmith et al. (2008), Honos-Webb et al. (1998, 1999), Stiles et al. (1990, 1992), and many other case study reports. In practice, a key aspect of the assimilation model is the way that it uses the concept of ‘voices’ (Honos-Webb and Stiles 1998). For instance, a warded-off experience can be viewed as a ‘silenced’ voice within the client’s self. As this muted or silenced voice becomes more able to be expressed, it takes its place in the ‘community of voices’ that comprise the client’s personal reality. The ‘community of voices’ implies that therapeutic change occurs not so much through the elimination or suppression of difficult experiences (e.g. ‘just forget it’) but through their acceptance (i.e. listening to silenced and vulnerable inner voices).

## Box 5.2: The community of self

The idea that parts of a self might be viewed as constituting a community was suggested by Mair (1977). He described the case of one client who imagined his 'community of self' to comprise a 'troupe of players'. Some of the main characters within this troupe were the 'producer', whose job was to take responsibility for what was happening 'on stage', the 'conversationalist', an actor who enjoyed relaxing in good company, the 'businessman', the 'country bumpkin', and several others. As he reflected on this way of thinking about himself, Peter realised that his 'dreamer' self, who generated a lot of ideas that were useful for other characters, was too easily silenced by the autocratic 'producer'. He also realised that the troupe as a whole was guided by a 'council', which had not been very effective in helping the different characters to communicate with each other. Peter initiated a programme of 'community development', to increase understanding and communication between members of his troupe, with the goal of preventing situations where the 'producer' would need to exert arbitrary authority. This was therapeutically helpful for Peter, in enabling him to be more resourceful in terms of how he dealt with stressful situations in his life.

## Openness to new experience

A crucial helpful aspect of therapy is that it might lead to something new happening. A person who is struggling with problems may see themselves as being locked into a repetitive pattern of negative experiences. In such a context, new experiences may represent solutions to current problems, may be energising and motivating, or may provide ways of moving forward that were previously unimaginable.

Within the counselling and psychotherapy literature, life-enhancing new experiences have often been described as 'corrective emotional experiences' or 'corrective experiences'. The concept of 'corrective' relates to the idea that at an earlier point in their life, an individual has learned a way of responding that may have been necessary at an earlier stage of life, but which is no longer functional, and that therapy is able to 'correct' this response by providing a more satisfying or functional way of being. The earliest version of this perspective, developed within psychoanalysis in the 1940s, was that the relationship with the therapist could operate as a 'corrective emotional experience'. For example, if, during childhood, a person had learned that questioning their parents would lead to punishment and rejection, they might develop a pattern in which they were unassertive in relationships with their spouse or co-workers, for fear of their reaction. In the safe environment of the therapy room, such a person might be able to experiment with what it might be like to be critical of their therapist. If they found that their therapist was open to their suggestions and feedback, they might learn that asking questions and making suggestions was actually quite a normal thing to do. They might then try out such responses in everyday life and discover that they resulted in more satisfying relationships.

More recently, the concept of 'corrective experience' has been defined more broadly, to refer to any event in therapy through which a person comes to understand or emotionally experience an event or relationship in a different or unexpected way (Castonguay and Hill 2012). An example of this kind of broader meaning of corrective experience can be found in a detailed case study published by Friedlander et al. (2012), which reported on therapy received by a woman of 35 who was struggling with panic and anxiety. One of the corrective experiences that occurred for this client was linked to exploring an event in early childhood in which her mother had left her alone in a shop and had driven home without her. Through revisiting this event with the help of her therapist, the client was able to develop a new understanding of what had happened, and also experience new emotions – she became angry with her mother, and was then able to forgive her.

There are many types of new experience that can occur in therapy. A person may talk for the first time about an aspect of their life that has been shameful or embarrassing, or too emotionally painful to put into words. A person may acquire a new skill or strategy around how to handle something that



has been problematic for them – for example, being taught a breathing technique to control fear, or using appropriate eye contact to feel more in connection with another person. There are many possible new experiences arising from moments of insight and self-understanding. Therapy may make it possible for a person to expand their circle of social support and involvement.

Positive emotion represents an important dimension of new experience. It is clear that people seek therapy because they want to deal with various types of emotional pain, and need to talk about that pain. However, moving forward in life usually requires acquiring more of a balance between painful experiences and positive experiences and emotions such as pleasure, excitement, curiosity, flow, generosity, relaxation, and fulfilment. The ‘broaden and build’ model of change offers a valuable way of making sense of this process (Fitzpatrick and Stalikas 2008; Fredrickson 2001). Negative emotions such as fear and loneliness tend to narrow personal horizons, because the individual is preoccupied with that feeling state and tends to focus their attention on it. Negative feeling states also tend to reduce energy and motivation. By contrast, the experience of positive emotions opens up new horizons, because the person has the energy and confidence to try new activities. In addition, being able to access both positive and negative states of feeling may have the effect of allowing the person to have a more differentiated response to situations, which contributes to better coping.

Therapy can be viewed as a context in which a person can identify new ways of thinking, feeling, and acting, which can then be implemented in everyday life. Therapy thus comprises a cultural ‘renewal mechanism’ that allows individuals and groups to adapt effectively to emerging challenges. Most approaches to therapy maximise the potential for generating new experience by being organised around activities that are different from the person’s normal everyday experience. These activities can be simple, such as being exposed to someone who listens very carefully, or they can be more dramatic, such as being asked to talk to an empty chair, or drawing a picture of one’s feelings.

The process of making use of life-enhancing new experiences can be understood in terms of both micro-sequences of therapist and client interaction, and also in terms of longer episodes. For example, what happens immediately before, and after, a client takes the major step of disclosing for the first time that they have been abused in childhood? What are the more extended processes, such as testing the trustworthiness and competence of the therapist, that laid the groundwork for that event? What are the longer-term consequences, for example the impact on the person’s ongoing relationships with others of telling them about the abuse?

### Box 5.3: Innovative moments

Usually, at the start of therapy, the story told by the client will be fairly repetitive and ‘problem-saturated’. A valuable therapeutic process is to focus on the strengths of the client, in the form of paying close attention to any client statements that represent solutions to their problem, or accounts of achievements or pleasure. In their research on ‘innovative moments’ in therapy, Gonçalves et al. (2008, 2010, 2012) found that clients described several different types of new perspective on their problems: reflections; descriptions of new experiences; new types of action or behaviour; complaining or protesting about problems; and re-conceptualisation. Their analysis showed that clients typically generate several innovative moments in each therapy session. They suggest that the job of the therapist is to be sensitive to subtle ways in which the client describes their experience, to take note of innovative moments, be curious about them, and see where they lead.

### Intensity, resoluteness, and courage

The change processes discussed above – behaviour change, coming to terms with internal conflict, and openness to new experience – should not be regarded as providing a comprehensive account of what happens in therapy: clients and therapists are endlessly creative in finding new ways to create

value from the experience of therapy. Nevertheless, they represent the essential building-blocks of most therapies. What is clear, on the basis of evidence from both clients and therapists, is that in order to make a difference to the life of the client, these change processes need to be pursued in an intense and persistent manner. Hanna and Puhakka (1991) used the term ‘resolute perception’ to describe the client attitude that is necessary for success in therapy. They suggest that the client needs to purposefully direct their attention towards topics and areas of experience that they would normally avoid, shun, or withdraw from. Even though different approaches to therapy employ different techniques and ideas, all of them require the client to be actively involved in applying these methods to the problems for which they are seeking help. This perspective is consistent with the notion that *courage* is a central aspect of effective therapy (Goldberg and Simon 1982; Tsai et al. 2013). Halvorsen et al. (2016) provide a case example of therapy in which client and therapist courage emerged as a central theme. The intensity associated with effective therapy is also exhibited by the fact that, for many clients and therapists, thoughts, feelings, images, and dreams about therapy sessions spill over into their everyday life (Bimont and Werbart 2017; Schröder 2009; Stewart and Schröder 2015).

### Box 5.4: It can be helpful for clients to listen to recordings of their therapy sessions

The use of process analysis of session recordings has proved to be an invaluable learning tool for therapists. However, it can also be valuable for clients to listen to recordings of their therapy sessions. Shepherd et al. (2009) routinely made audio recordings of therapy sessions with clients, for purposes of training, supervision, and research. After a while, they began to offer clients the option of taking home their own copy of the recordings each week. Later, they carried out a study into how clients felt about this procedure, and found that the majority of their clients regularly listened to the recordings and reported that doing this had made a positive contribution to their experience of therapy as a whole. Similar conclusions were reported on the basis of an individual practitioner initiative by Talbot (2015).

The value for clients of being able to reflect on recordings of their meetings with therapists is supported by evidence from other areas of healthcare, in which this activity is more widely practised (Elwyn et al. 2015; Rieger et al. 2018).

## Finding what helps

One of the most useful ways to think about the process of therapy is to consider which aspects of therapy have been helpful or unhelpful. Not everything that a therapist does is necessarily helpful. Clients are active in choosing, selecting, and adapting from what the therapist offers, to find what will be most helpful for them. The concept of the ‘active client’ was developed by Bohart and Tallman (1999) to describe this aspect of therapy. A great deal of research has focused on what can be described as ‘process–outcome’ links – the types of therapy events and processes that lead to good or poor outcomes. It is hard to determine exactly which processes are most helpful, because almost always several processes are unfolding at the same time, and it is difficult to disentangle the effect of each of them. A strategy that has been productive in this area of inquiry has been to ask clients to identify the events and processes that they have experienced as helpful or unhelpful. The following sections explore the concept of helpfulness from these different perspectives.



## Micro-analysis of helpfulness

One strategy for developing a deeper understanding of what is helpful in therapy is to look at the immediate impact of specific therapist responses. This approach looks for links between therapist actions and ‘small-o’ outcomes (i.e. beneficial shifts within brief time-scales). By contrast, it is much harder to find links between specific therapist actions and ‘large-O’ outcomes (i.e. shifts between start and finish of therapy as a whole) because it is hard to isolate the effect of one aspect of therapy when there are many helpful processes happening at the same time.

Within this approach to examining helpfulness, an important body of process research, led by the German psychotherapist Rainer Sachse, has focused on the micro-analysis of ‘triples’: sequences of therapist–client interaction in which the client speaks, the therapist responds, and then the client responds to the therapist’s intervention (Sachse and Elliott 2002). This research has examined the ways in which different types of therapist empathic response can influence the depth of experiencing being displayed by the client.

For example, a client may say: ‘Only yesterday I noticed again how terribly worried I get when I’m telling somebody a story and he is not listening to me at all’ (example from Sachse and Elliott 2002: 94). In this statement, the client is speaking personally, but with relatively limited elaboration of the underlying meaning of this type of incident, or the feelings associated with it. The therapist can respond at any one of three levels, each of which may have a different impact on the way that the client continues to process their experience at that moment. For example, a flattening response, such as ‘who was with you at the time?’, would be likely to divert the client into factual detail, and away from further exploration of feelings and meaning. A maintaining response, such as ‘you really feel that it bothers you’, would have the probable effect of holding the client at the same level of processing as their initial statement. However, a deepening response, such as ‘what does it mean to you, to get terribly worried?’, will tend to influence the client in the direction of greater depth of experiential processing, at their subsequent speaking turn.

The findings of an extensive programme of research into the role of therapist as ‘process facilitator’ (Sachse and Elliott 2002), which has examined the impacts of different types of therapist responses, has found that:

- the level of processing exhibited by the therapist has a consistent impact on the depth of processing expressed by the client – around 60 per cent of the time, clients match the depth of processing embodied in the preceding therapist statement;
- clients relatively rarely shift in the direction of greater depth of processing, in the absence of the therapist modelling such behaviour;
- clients are more sensitive to ‘flattening’ responses than to ‘deepening’ ones.

The implications of this research suggest that, in attempting to understand the process of therapy, it is essential to consider the effect on the client of preceding therapist interventions or statements. The evidence suggests that even if clients are engaged in a process of actively exploring the emotional and personal meaning of an aspect of their experience, they can be brought to a halt by an over-concrete or factually oriented therapist response. By contrast, clients who may appear to be stuck in a process of merely reporting everyday events, can be encouraged to explore the meaning of these events if the therapist responds in an appropriately ‘deepening’ manner.

The work of Sachse and Elliott (2002) represents just one example of micro-analyses of helpful processes – in this instance, therapist empathic responding. The same general framework can be applied to the exploration of the helpfulness of any type of therapist response, as long as an audio or video recording of a therapy session is available. A particularly comprehensive analysis of the helpfulness of therapist immediacy (i.e. commenting on what is happening in the interaction between therapist and client) can be found in a series of detailed investigations of how therapist immediacy is received by a client. These studies include analysis of immediacy-facilitated processes in single sessions as well as over the course of a whole case (Clemence et al. 2012; Hill et al. 2008, 2014; Kasper

et al. 2008; Mayotte-Blum et al. 2012). Outcomes from these studies have been used to design training in immediacy skills for therapists (Spangler et al. 2014).

The findings of research into helpful micro-processes in therapy do not yield definite rules of the form 'this type of empathy/immediacy always has a certain type of effect on the client or the therapy relationship'. Instead, this kind of research has the potential to *sensitise* therapists to possibilities, in a way that enriches their capacity to be responsive to clients.

### Box 5.5: The use of metaphor to deepen the therapeutic process

At the moment of moving another step more fully into their experience of a problematic issue, a client may be literally 'lost for words'. At these moments, metaphors and images may be the only way that a person can convey what they mean. To explore this aspect of the process of therapy, some researchers (Angus and Rennie 1988, 1989; Rasmussen 2000; Rasmussen and Angus 1996) audio-recorded therapy sessions, and then invited the client and the therapist to listen to sections of the tape in which vivid metaphors were used, commenting on their experience during these events.

In one case described in Rasmussen and Angus (1996: 526), a client was tearfully recalling experiences in which she had felt that her mother had behaved towards her in a dismissive fashion. Her therapist offered the following reflection: 'It sounds very intense to me. The feelings in it. Like, cut right to the bone'. In the research interview conducted after the end of the therapy session, the client noted that, at this point in the session, she had been 'feeling completely lost in a sea of emotions'. When asked to comment on the counsellor's metaphor, 'cut to the bone', she stated that: 'That was a good way of putting it . . . It really kind of epitomises how I am feeling right now . . . kind of the heart of the matter at that point'. This simple statement by the therapist ('cut right to the bone') was able to pull together several crucial aspects of the client's experience (the pain of what had happened, the pain being inflicted by another person, the sense that it could go no further without breaking the bone itself) and thereby allow the client to develop a more coherent perspective on the issue she had been exploring. This metaphor, like so many other metaphors that arise in therapy, draws on an image derived from a domain of bodily experiencing (Sharpe 1940).

Further research into the role of metaphor in the therapeutic process has been carried out by Angus (1996), Lawn et al. (2016), Levitt et al. (2000), Long and Lepper (2008), and Shinebourne and Smith (2010).

### The client's experience of what is helpful

Research into what happens in therapy at a micro-process level makes it possible to focus on the ways in which specific processes unfold. It is a form of research that is time-consuming and complex to organise. A more straightforward way to investigate the helpfulness of different aspects of therapy is to ask the client. This kind of research also has the advantage that it can be readily transported into practice – a therapist can ask their client about what has been helpful or unhelpful for them in the work they have been doing together. From a client perspective, this area of research underscores the value for clients and service users of actively monitoring their own sense of what is working in therapy, and feeding this information back to their therapist.

Many techniques have been devised for collecting information about client experiences of helpfulness, including interview guides, questionnaires, and brief forms completed after sessions. Further information on these techniques can be found in Cooper and McLeod (2015) and McLeod (2017b).

Two main themes emerge from research into client perceptions of helpful factors in therapy. The first is that clients report many different types of experience as being helpful (Swift et al. 2017; Timulak 2007) – this line of inquiry does not support the primacy of change events and processes associated with any one model of therapy. The second theme is that clients often describe helpful aspects of therapy that are somewhat surprising, and not consistent with the approach taken by their therapist. This second theme has a great deal of practical significance, because it suggests that the concepts and theories used by therapists do not actually take account of all aspects of what happens in therapy, and that, in particular, therapy looks rather different from the point of view of the client.

Many studies of client perceptions of helpfulness have been published. Borrill and Foreman (1996) interviewed clients who had received cognitive-behavioural therapy for fear of flying. This is an approach to therapy that emphasises a change process focused on being able to develop new ways of thinking about a problematic experience. What Borrill and Foreman found was that although clients did acknowledge the helpfulness of the cognitive techniques they had learned, they reported that the crucial helpful aspect of therapy was the personality of the therapist, in particular how credible and trustworthy they were considered to be – it was only by believing in the therapist, and what they had suggested, that they felt able to try out these techniques in real-life situations. Poulsen et al. (2010) interviewed clients about what had been helpful and unhelpful in psychodynamic psychotherapy they had received for an eating disorder (bulimia nervosa). The authors found that all of the clients reported difficulties in grasping the value of the non-directive and unstructured approach adopted by their therapist, with some clients remaining critical and resentful even at completion of therapy. A wholly unexpected finding was that some clients found it unhelpful to work with a therapist who did not appear to have any personal issues around eating or bodily appearance. The studies by Borrill and Foreman (1996) and Poulsen et al. (2010) illustrate the ways in which exploring client views around helpfulness can contribute to a better understanding of the process of therapy.

One of the strengths of qualitative helpfulness studies is that they offer a detailed analysis of the experiences of a specific set of clients undergoing a particular form of therapy at a particular time and place. However, readers of such research may find it hard to see how the findings of such studies apply in the circumstances in which they work as therapists, or are receiving therapy as clients. A valuable approach for developing a more generalisable understanding of helpfulness has been to interpret the findings of such studies in terms of broad principles of therapy that are potentially applicable in all situations (Levitt et al. 2005). This strategy has been pursued in the work of the American therapy researcher Heidi Levitt (Levitt et al. 2006, 2016).

Examples of general principles of helpful therapy identified by Levitt et al. (2016) include:

- Therapy is a process of change through structuring curiosity and deep engagement in pattern identification and narrative reconstruction.
- Caring, understanding, and accepting therapists allow clients to internalise positive messages and enter the change process of developing self-awareness.

These are complex, evocative statements that go beyond conceptualisations of helpfulness framed in terms of single client or therapist activities. Instead, they provide a nuanced understanding. For instance, it is not just that 'curiosity' is a characteristic of helpful therapy – curiosity needs to be channelled or structured, and leads to different types of outcome (pattern identification and new ways through which the client tells their story). The idea of principles of therapy helpfulness based on qualitative research into client – and therapist (Levitt and Williams 2010) – experiences of therapy is relatively novel, and to date has generated only a handful of studies. Nevertheless, it appears to have the potential to enable both clients and therapists to retain a focus on what is important in therapy (e.g. curiosity and a caring approach).

## The client's experience of what is unhelpful

It is essential to pay attention to what is helpful in therapy, as a means of maximising productive and facilitative processes. However, in some respects it is even more essential to pay attention to what is not helpful. Unhelpful or hindering processes can reduce the effectiveness of therapy, trigger the client leaving therapy, and in some cases may result in harm to clients (Henkelman and Paulson 2006). The issue of unhelpful aspects of therapy is not trivial: around 30 per cent of clients have unplanned endings, usually associated with dissatisfaction or disappointment with treatment (see Chapter 6), and around 10 per cent of clients get worse over the course of therapy (Lambert and Ogles 2004). Questionnaires that have been developed to enable clients to report on negative effects have found that participants endorse a wide range of different types of unhelpful experience, ranging from an increase in symptoms to losing faith in oneself, the surfacing of unpleasant memories, and not being able to make decisions without help from their therapist (Rheker et al. 2017; Rozental et al. 2016).

While it is clear that client dropout and deterioration can be due to a range of factors that have nothing to do with the process of therapy, it is also clear that a significant proportion of these negative outcomes are a result of unhelpful aspects of the therapy itself. Paulson et al. (2001) interviewed clients about things they believed had hindered or impeded their therapeutic progress. These clients generated a long list of hindering factors: feeling vulnerable, lack of connection with the therapist, uncertain expectations, not being understood, specific unhelpful interventions from the therapist, lack of therapist caring, and lack of structure. Researchers who have interviewed clients who have been disappointed with the therapy they have received, typically find that dissatisfied clients have been exposed to therapists who are not flexible enough to find common ground with their client, but persist with a fixed therapeutic approach even when this is not effective for the client (Lilliengren and Werbart 2005; Nilsson et al. 2007). These therapists may be highly effective with clients whose way of working closely matches their own, but are not flexible enough to accommodate the requirements of clients who have a different agenda.

### Box 5.6: The impact of therapist self-disclosure on the therapeutic process

Therapy involves the client doing the talking, and the therapist listening and facilitating. Traditionally, therapists have been trained to abstain from talking about themselves in the therapy room, sometimes even to the extent of not being willing to acknowledge whether they are married or single, gay, or straight. There has been a tendency to regard the curiosity of the client about their therapist as something to be interpreted, and any desire on the part of the therapist to disclose personal material ('my mother died too, and I know that it affected me deeply') as an unhelpful departure from role. In recent years, however, research into the impact of therapist self-disclosure on the therapeutic process has allowed a more nuanced appreciation of therapist self-disclosure to emerge. It is important to differentiate between self-involving statements and self-disclosure statements. A self-involving statement can be viewed as a form of immediacy, for example if a therapist states that 'as you were talking, I was aware of feeling confused, then sad . . .'. Here, the therapist is making reference to a here-and-now personal response to the client. Self-disclosure, on the other hand, refers to the counsellor sharing personal biographical information ('I am married', 'I am gay').

Guidelines for effective use of therapist self-disclosure can be found in Farber (2006), Hanson (2005), Henretty and Levitt (2010), Hill and Knox (2001), Knox and Hill (2003). Research on this topic has been reviewed by Henretty et al. (2014).

Studies that have looked more closely at aspects of therapy experiences that are not only hindering but are perceived by clients as actively harmful, have similarly identified many potentially damaging therapist practices (Binder and Strupp 1997; Crawford et al. 2016). In one study in which people recovering from depression were interviewed, van Grieken et al. (2014) found that participants felt that their progress was impeded by a lack of agreement between their ideas about what would help and the assumptions of their therapist, an uncaring and inflexible treatment system, and an unwillingness to consider involving other people in their life (e.g. family, members of their community). In general, the most significant harmful practices are associated with therapists who are over-confident in the validity of their own theory and approach (and who seek to impose their views on the client), and who exhibit judgemental or critical attitudes towards their client (Bowie et al. 2016; von Below and Werbart 2012).

The literature on negative processes in therapy shows that what is unhelpful in therapy is not just the mirror image of what is helpful. In therapy, the client puts themselves in a position of emotional vulnerability in relation to the therapist, and needs the therapist to look after them in a positive way. In such circumstances, the actions of an over-rigid or unresponsive therapist can be experienced as deeply wounding.

## Staying on track

Although change can sometimes occur in a single session of therapy, or a small number of sessions (for example, see section on single-session interventions in Chapter 31), for most clients any benefit from therapy requires sustained effort over several (or many) sessions. One of the challenges that can emerge is that of staying on track – there are many ways in which therapeutic momentum can be lost. The following sections consider the issue of staying on track from two contrasting perspectives. First, there is an exploration of how therapy gets stuck, and how such impasses can be resolved. That is followed by an exploration of using client feedback to the therapist as a means of avoiding getting stuck, and addressing ‘stuckness’ as soon as possible.

## Resolving impasses

The concept of ‘impasse’ is widely used to describe situations in which therapy is stuck or stalled. The literal meaning of ‘impasse’ refers to a street with a dead-end, in which no further progress towards a desired direction of travel is possible. There are many possible reasons why this can happen:

- The client has made good progress, and needs to take time out to consolidate.
- The client has made some progress, but is now in a position where they need social support and everyday opportunities, in order to go further.
- The client is unhappy with their therapist as a person, or the way in which the therapist has been working with their problem.
- The client is not ready to change.
- The next step that the client might take (e.g. describing a traumatic event in vivid detail) is too frightening or shameful to contemplate (or they do not feel sufficiently safe and supported by the therapist or therapy clinic to do so).
- The client is in the horns of dilemma, and is faced by two (or more) choices or potential courses of action, both (or all) of which are equally appealing/unappealing.
- The client is considering a solution to their problems (e.g. suicide) that they are not willing to discuss with their therapist.
- The momentum of therapy is interrupted by sickness absence, a vacation, etc.

- Psychotherapy is not an appropriate or effective form of help in respect of the particular problem(s) experienced by the client.
- The issues being explored by the client are so uncomfortable and threatening to the therapist that they are using various strategies to distract the client from pursuing them.
- The therapist is working outside or beyond their competence – they are unable to understand the client's problem or offer effective forms of help.

This is an incomplete list. Useful resources for appreciating the diversity of forms of impasse that can occur in therapy, and the nature of therapists' successful (and unsuccessful) attempts to resolve impasses, can be found in the analysis of therapists' experiences of impasses by Hill et al. (1996) and the edited collection of therapist stories collected by Kottler and Carlson (2009).

Any form of impasse may be exacerbated by the intensity and longevity of the problems for which the client is seeking help. To give an extreme example, a person with a life history of abuse and adversity is likely both to find it hard to trust a therapist and, once a therapeutic process is underway, will repeatedly encounter painful areas of experience that may trigger avoidance and activation of personal safety.

The basic strategy for addressing any of these forms of 'stuckness' is for the therapist or client to acknowledge that things do not appear to be progressing well, to talk about the situation, and, as a result of what comes out of that conversation, to adjust the therapy accordingly or bring therapy to a close. This kind of repair process can be difficult to accomplish, because it calls for a capacity to work collaboratively that may never have existed, or may have been eroded, or because the underlying issues that have caused the impasse are hard for the therapist or client to talk about or are operating out of conscious awareness.

The most widely used models of therapy impasse resolution are the alliance rupture repair model developed by Jeremy Safran and Christopher Muran (see Chapter 3), and the use of clinical supervision. Therapists influenced by the psychoanalytic tradition sometimes use the term 'resistance' as a general term for explaining impasse, and therapists within the behavioural tradition sometimes attribute 'stuckness' to a lack of readiness to change. From within the person-centred or Rogerian position, Mearns (1994) suggested that impasses arise from therapists' over-involvement or under-involvement with the client (i.e. the inability of therapists to offer an appropriately facilitative relationship). Beyond these explanations, there exists a substantial literature on clients who are 'hard (or difficult) to treat' due to personality characteristics such as borderline personality, avoidant personality, narcissism, or schizophrenia (Munich and Allen 2003).

Further perspectives on the resolution of therapy impasse have been described by Cohen (2016) and Moltu et al. (2010). In a detailed case study analysis of his experience of impasse with a long-term client, Cohen (2016) describes how psychoanalytic therapy had been beneficial for the client in many areas of his life, but that therapy stalled around how to address the specific issue of recurring bouts of destructive self-criticism. Following a review and discussion of the situation, the therapist and client agreed together that it might be beneficial to shift to a more cognitive-behavioural approach – something that was somewhat outside of the comfort zone of both participants. This new therapy model proved to be effective. Moltu et al. (2010) interviewed experienced therapists to describe a particularly difficult impasse case within their practice, and how they handled it. These therapists talked about the personal emotional impact of working with a client when therapy was stuck, and that arriving at a successful resolution required coming to terms with their own emotional responses, to prevent these feelings from undermining the therapy process. With such clients, these experienced therapists became more and more trapped in a heightened state of emotional reactivity within sessions, characterised by feelings of personal despair and irritation with the client. They addressed these feelings by revisiting positive feelings around their basic intention and commitment to be helpful, and reflecting on their sense of lost hope and their ability to remain present while feeling under threat from the client.



It is important to recognise that impasse may not necessarily reflect an underlying problem in the client–therapist relationship or in the psychological functioning of the client. In some instances at least, when an impasse is acknowledged and explored, it may be apparent that it is a signal that it is time for therapy to end, or for the client to make use of different types of learning experiences. It sometimes emerges that what is needed is an adjustment to therapy arrangements – for example, a shift to longer sessions that allow the client more space for entering difficult emotions, or to a different time of day when the client may feel freer to open up (e.g. not faced with having to go straight back to work immediately after a session).

In summary, the experience of impasse in therapy is common, and it occurs in different ways. Despite the existence of multiple strategies for addressing impasse, it represents a challenging and difficult issue for both clients and therapists. An important implication of issues around ‘stuckness’, impact, and stalled therapy process is that it is valuable for therapists in training to receive specific training on how to manage their own emotional responses, and how to use effective therapeutic strategies when such situations arise in their practice (Grant 2006).

### Box 5.7: Transformative moments

Transformative moments represent the opposite of the experience of impasse in therapy. A transformative moment is like an epiphany, a step forward into a new way of understanding and feeling about oneself, that is positive and hopeful. The best description and analysis of such events in therapy can be found in the writing of Daniel Stern (2004). It does not appear that such moments can reliably be manufactured or predicted. No one knows how often they occur in therapy.

### Using feedback

The use of brief outcome and process measures, completed by the client at every session, has been a major area of innovation in counselling and psychotherapy practice over the last 20 years. These developments were made possible by the availability in the 1990s of short, widely accessible questionnaires, that could be filled in by the client without taking up too much time, and easily analysed by the therapist or an administrator. At that time, there was a growing recognition of the significance of poor outcome in therapy – the high proportion of clients with unplanned endings, and the smaller but still meaningful proportion who deteriorate over the course of therapy. These clinical challenges were exacerbated by evidence that clients tend to be deferential to their therapists around their dissatisfaction with the way the therapist approaches their problems (Rennie 1994a) and that therapists are poor at detecting signs of lack of progress (Hatfield et al. 2010). Arising from all these considerations, the use of client feedback and monitoring systems was pioneered by two groups of researchers and practitioners – one directed by Michael Lambert, and the other by Scott Miller and Barry Duncan.

The key principle that informed these initiatives was the idea that client ratings of symptoms and outcome, and how they perceive the therapy process and relationship, would provide a valuable source of information to both the therapist and client that could be used to adjust their work together. This feedback information was envisaged as fulfilling two contrasting functions. From one perspective, feedback information was primarily regarded as operating akin to a thermometer or stethoscope – providing the expert clinician with data over and above whatever they could observe within the course of normal interaction with a client. From another perspective, feedback information has been regarded as forming the basis for a conversation between the client and therapist that



supports a collaborative way of working (Sundet 2009, 2012a, 2012b). Although these perspectives clearly overlap – it is possible to use feedback data for both purposes within the same therapy session – in practice, therapists and therapy clinics that have adopted feedback and monitoring systems have tended to lean in one direction or the other.

It is not possible, in the space available, to do justice to the massive outpouring of theory, research, and practice innovation associated with the use of feedback and monitoring tools. Information about the main feedback systems can be found in Barkham et al. (2015), Duncan and Reese (2015), Lambert (2015), Miller et al. (2016), and Overington and Ionita (2012). Accounts of emergent and innovative developments are available in McLeod (2017b), Moltu et al. (2018), and Sales and Alves (2012).

Structured feedback procedures have been regarded within the therapy professions as a simple, cost-effective adjunct to routine practice that has the potential to make a significant contribution to client satisfaction and outcome. Feedback also has the potential to reduce the number of sessions taken up by clients, by providing information about when the client is ready to finish (i.e. their symptom scores are in the normal range).

In relation to the key themes of the present chapter – the process of change, and therapy as hard work – the literature on feedback and tracking systems has highlighted a number of processes that have broader implications for aspects of therapy. One of the reasons why clients find feedback helpful is that they are already engaged in trying to determine whether they are getting better, and feedback gives them a much clearer idea of where they are in respect of this issue. Research by de Jong et al. (2012) found that feedback is only beneficial when the therapist themselves is open to such information: therapists vary in the extent to which they are able to do this, and these differences appear to be linked to underlying personality factors. Meaningful participation in the feedback process, on the part of both client and therapist, is shaped by the extent to which they view feedback measures as being administered primarily in the interests of therapy (i.e. under their control) or merely as a form-filling exercise that is conducted in the interests of an external body such as the managers of the therapy clinic or the government. As with other therapy processes that have been studied, the process associated with using feedback measures is neither unequivocally helpful or hindering. Instead, the process can unfold in different ways, depending on the people involved, and the context within which they are working. In addition, both therapist and client have the ability to modify and personalise the process to maximise its usefulness.

### Box 5.8: Task analysis

The concept of ‘task’ is widely used in the therapy literature to refer to a piece of therapeutic work that has the aim of achieving a particular goal. ‘Task analysis’ consists of mapping the sequence of therapist and client activities that comprise specific tasks (Benítez-Ortega and Garrido-Fernández 2016). A key aim of task analysis is to be able to differentiate between task sequences that produce the desired end-point and sequences that lead in unhelpful directions. An example of task analysis is the study by Kannan et al. (2011), which identified an effective task sequence for the resolution of anger: (1) exploration of a specific problematic anger situation, (2) moving into a cycle of clarifying the threat, owning emotions, and tying anger to past events, (3) reframing the problem, and (4) considering options to initiate change. Anger-focused episodes in therapy that did not follow this sequence were unlikely to lead to problem resolution. Task analysis has been highly influential in highlighting the importance of direct experiencing of emotion (as opposed to talking ‘about’ emotion) in therapy (Pascual-Leone and Greenberg 2007).

## The covert dimension of process: what is going on under the surface

One of the most fascinating aspects of therapy process arises from the fact that both client and counsellor conceal a great deal of information from each other. If the aim of analysing process is to gain a fuller understanding of what is happening in a therapeutic encounter, in the interests of facilitating its effectiveness, one of the most productive strategies is to pay attention to what is not said. Regan and Hill (1992) carried out research in which they asked clients and therapists at the end of each session to list 'things not said'. Blanchard and Farber (2016) and Love and Farber (2017) asked clients to indicate topics they had concealed from, or lied about to, their therapist. Both studies provide evidence that clients avoid talking about topics that they find shameful or distressing, suicidal impulses, and criticisms about the process of therapy or the personality and style of the therapist. In other words, areas that are crucial to the progress of therapy are not talked about. Similarly, therapists hold back on sharing inner thoughts, feelings, and memories that have the potential to enhance the therapeutic process (Rober 2011; Rober et al. 2008).

In research into clients' experiences of therapy, Rennie (1994a, 1994b) found that there were many ways in which clients chose to conceal their thoughts, feelings, and intentions. For example, clients might defer to their therapist by saying nothing if they felt the therapist had misunderstood them or asked an irrelevant question. Other clients reported to Rennie (1994b) that sometimes they overtly talked about things that were not really all that important, while covertly they might be running through another issue, or weighing up whether they felt ready to introduce into their story particular events or areas of experience that were painful or embarrassing.

The implication of these studies is to reinforce the idea that there is a lot going on 'behind the scenes' in any therapy encounter. To make sense of process, therefore, requires gaining as much access as possible to this hidden material. In his research, in order to access this material, Rennie used interpersonal process recall (IPR) (Baker et al. 1990; Elliott 1986; Kagan 1984; Kagan and Kagan 1990; Kagan et al. 1963), a systematic method based on asking both participants to listen (usually separately) to the tape of one of their therapy sessions and comment on what they had been experiencing during the original interaction. If this task is carried out within 24 hours of the session, the informant is able directly to recall a lot of what went on. The longer the recall interview is delayed, the less the person will remember.

An example of an IPR study is that of Williams and Levitt (2008) into clients' experience of difference between them and their therapist. In this study, participants were invited to define 'difference' as referring to whatever domain of difference was relevant to them. Audio recordings of therapy sessions were made, and clients were asked to listen to these sessions, identify episodes where they identified difference, and talk about what had been happening for them during that time. This study offers a new appreciation of client sensitivity to difference. Clients proved to be highly vigilant about any possibility of a rift developing between them and their therapist, because they felt that it would threaten their faith in themselves, in the therapist, and in their belief in the potential helpfulness of therapy. As a result, they worked hard to avoid the development of difference, and conducted a lot of covert work around rationalising any differences that had emerged. This study is notable in drawing attention to the importance of difference for clients. Probably most therapists would be vaguely aware of this issue, but not of how pervasive and sensitive it is for clients.

In everyday ongoing counselling and psychotherapy, ethical and practical constraints largely preclude the use of IPR. In these circumstances, the covert process of therapy will only be recovered to the extent that the client and therapist are willing to disclose and explore it in sessions. However, it is feasible for therapists to examine their inner experience by writing notes afterwards that focus on what they felt as well as what the client said and did, and by exploring this topic with their supervisor. It is also helpful for a therapist to invite their client to talk about what is 'unsaid', and what might be stopping the client from saying it.

### Box 5.9: The Goldilocks Effect

It has proved difficult for the counselling and psychotherapy professional community to construct a coherent and comprehensive understanding of the process of therapy. Part of the problem has been a tendency to look for linear connections between factors: more of process variable X will produce more of outcome variable Y. Stiles and Shapiro (1989) argued that such assumptions reflect what they called the 'drug metaphor' (i.e. a bigger dose of a drug produces a greater effect). A study by McCarthy et al. (2016) provides a vivid illustration of this issue. They analysed links between therapists' use of specific process techniques (such as empathy, interpretation, encouraging expression of emotion) and outcome defined as a reduction in symptoms. What they found was that therapists who exhibited high or low levels of a technique did less well than those who exhibited a medium level. They called this the 'Goldilocks Effect': too much or too little therapist self-disclosure, empathy, or interpretation was not helpful – what the client needed was a level that was 'just right'.

## Conclusions

Process is all about the flow of what happens in a therapy session. Most of this flow is probably beyond conscious control, by either party, either because it occurs so quickly or because it is so multidimensional and complex. Yet this is the environment in which both the therapist and client must operate. Ivey (1995) has described therapy as an *intentional* activity. What he means by this is that all of us have probably unwittingly learned during our lives some ways of being helpful and facilitative to other people. To be a good therapist, it is necessary to be able to extend this repertoire when necessary, to be aware of when to work harder at being empathic and when to move instead into collaborative problem-solving mode, and so on. Theory and research on the process of therapy sensitise a therapist to the flow of process in ways that enable productive reflection around the pros and cons of alternative courses of intentional responsiveness in relation to a client. It is unlikely that clients will be interested in reading theory and research on therapy process. However, an awareness of process is equally relevant for clients, because it helps them to engineer therapy in the direction of getting what they need from it, and because the processes of learning and relating that occur in therapy sessions are similar to those that occur in everyday life – a therapy session can represent a microcosm and learning arena in respect of real-life issues.

Therapy is hard work. As with any other type of hard work, it can be exciting, energising, and fascinating. But it is important to acknowledge that, for most people, the gains of therapy do not come easily. The notion of therapy as hard work has a number of implications. It highlights the importance of the issues discussed in Chapter 4 – the importance of doing the groundwork that makes it possible to use therapy to build something worthwhile and lasting. It highlights the question of how many sessions of therapy are needed. Sometimes therapy can go on for too long, for example when progress is stalled but neither the therapist nor client is willing to contemplate finishing or trying something different. More frequently, in a social context in which there are powerful economic pressures to reduce healthcare costs, therapy is too short. It is neither ethical nor cost-effective to stop treatment before a client has completed the work they need to do. A further implication of the concept of therapy as hard work is that it is a reminder that entering therapy is an act of courage and resilience. For some individuals, there is still a perception of entering therapy as stigmatising, an indicator of personal weakness and dependency. The study of therapy process shows very clearly that the opposite is the case – clients are active, resourceful, and brave in using therapy to address the consequences of adverse life experiences.



## Topics for reflection and discussion

- 1 Looking back on your own experience as a client, or as someone being helped by another person in a less formal situation, can you identify particular helpful or hindering events? What were the main characteristics of these events that made them helpful or hindering?
- 2 To what extent does the assimilation model help you to understand processes of change in your own life? Are there personal experiences of change that do not readily fit into that model?
- 3 In formal counselling or psychotherapy in which you have participated, or other informal helping relationships, what are the topics or areas of experiences that you have avoided talking about – that have been unsaid? To what extent, and in what ways, did these non-disclosures affect the helpfulness of the therapy/help you received? What would have needed to happen for you to be more open about these topics?
- 4 How open are you to asking for, receiving, and acting on feedback from other people? In what ways has your openness to feedback influenced your effectiveness as a therapist or your experience as a client?

## Suggested further reading

A useful analysis of key processes in therapy can be found in Kivlighan (2014). The group at Stockholm University led by Andrzej Werbart has published a series of qualitative studies that vividly capture the process of therapy as experienced by clients and therapists (Lilliengren and Werbart 2005; von Below and Werbart 2012; von Below et al. 2010; Werbart et al. 2015, 2017). Detailed accounts of the unfolding process of therapy in individual cases are available in case studies published in the open access on-line journal, *Pragmatic Case Studies in Psychotherapy*. Key sources of reading for anyone interested in finding out more about client feedback and monitoring include overviews by Fitzpatrick (2012) and Lutz et al. (2015), and research reviews by Gondek et al. (2016), Ionita et al. (2016), Oanes et al. (2015), and Solstad et al. (2019).

# Chapter

# 6

## Leaving therapy

<b>Introduction</b>	<b>83</b>
<b>The experience of ending</b>	<b>84</b>
<b>Types of ending</b>	<b>85</b>
Unplanned endings	86
<b>Practical strategies for managing endings</b>	<b>87</b>
Preparing to end	87
How therapists facilitate the process of ending	88
<b>The impact of ending on the therapist</b>	<b>88</b>
<b>Conclusions</b>	<b>89</b>
<b>Topics for reflection and discussion</b>	<b>89</b>
<b>Suggested further reading</b>	<b>90</b>

### Introduction

The question of how a therapy will end is part of the process of therapy from the start. When they agree to work together, both client and therapist (or members of a family, couple, or therapy group) know that this is a professional relationship that will exist for a limited amount of time. What takes place during sessions depends on the time horizon that is available. For example, in-depth exploration of childhood experience is unlikely to yield much in one or two sessions. Therapy may finish for a wide range of reasons: the client may get better, the personal circumstances of the therapist or client may change, the money may run out, or either party might arrive at a conclusion that they are wasting their time. The professional literature around endings touches on areas of great sensitivity and vulnerability. For the client, one of the paradoxes of therapy is that the more one allows oneself to get closer to another, the more likely it is that the relationship will end. For both therapist and client, it can be painful to imagine not seeing someone who has been a companion on a significant personal journey. If the client just stops turning up, the therapist is left with unanswerable questions that may trigger self-doubt or guilt ('I should have done more', 'I am not good enough').

In most circumstances, the aim of therapy is to arrive at a point at which it is not necessary. People go to therapy in order to be able to have more satisfying, meaningful, and enjoyable lives. The end of therapy is a transition into being able to transfer what has been learned in therapy into everyday life situations. Therapists therefore have a professional responsibility to ensure that this transition proceeds as well as possible, not only in terms of positive outcomes but also the avoidance of harm. The challenge for the therapist at the ending phase is to use this stage of therapy to the maximum benefit of the client.

The present chapter provides an introduction to the ways in which endings are understood and handled by clients, counsellors, and psychotherapists. The following sections focus on the ways in which termination can be a positive experience, and on how to make sense of (and hopefully avoid) the occasions when it is not.

## The experience of ending

It is useful to anchor an understanding of therapy endings in an appreciation of the meaning of this process from the point of view of the client. A number of qualitative studies have used post-therapy interviews to explore the client's experience of ending therapy.

Knox et al. (2011) found that many of the clients they interviewed described positive experiences of ending, following a strong and supportive therapeutic relationship with their therapist, beneficial therapeutic impacts, and a sensitively planned termination process. These clients attributed the decision to end as being mainly due to external factors such as finance or change of location. These findings confirm that productive and satisfying therapy endings are possible. By contrast, other clients interviewed by Knox et al. (2011) described unsatisfactory endings linked to a sense of disappointment with therapy. For the most part, this latter group were highly motivated to make use of therapy, and found the limitations of their chosen therapist a 'bitter pill to swallow'. These observations imply that, from a client perspective, an unsatisfactory ending does not reflect lack of therapist skill and competence during the actual ending process, but instead a more fundamental problem in the therapy relationship.

Råbu and Haavind (2018) found that clients experienced a range of emotional tensions associated with the ending stage of therapy, and acknowledged in their interviews with a researcher that in many instances they had not felt able to discuss these tensions with their therapist. Roe et al. (2006) identified one of the major tensions experienced by clients as being caught between losing a meaningful relationship and wishing to celebrate a new sense of independence. Råbu et al. (2013b) observed that clients frequently used journey metaphors ('moving on') and organising metaphors ('sorting out', 'cleaning up') when talking about their negotiation around the decision of when to finish therapy – both types of metaphor offering down-to-earth strategies for resolving emotional tensions.

The themes that emerge from interviews with clients around their experience of termination are broadly consistent with the ways in which endings have been conceptualised by therapists. Quintana (1993) identified four main images of termination within the therapy literature: termination as loss, as crisis, as development, and as transformation. More recently, Maples and Walker (2014) proposed that the ending of therapy can usefully be viewed as a time of consolidation, and Schachter et al. (2017) have argued that it is useful to view termination as progression (to another phase of life). The distinctive contribution that is made by client-focused research is that, from the perspective of the client, these themes or challenges tend not to exist in isolation. Instead, clients are aware of struggling to reconcile two or more meanings of termination at the same time. In this respect, it is significant that clients report that they are unable to talk about important aspects of these tensions to their therapists. In studies in which therapist and client views are taken together, it has been shown that therapists generally do not fully understand what termination means to their clients (see Box 6.1).



## Box 6.1: How well do therapists understand clients' reasons for ending?

Research by Hunsley et al. (1999) suggests that, in many cases, therapists have a somewhat skewed and over-optimistic view of the state of mind of their clients at the point of termination. This study was based in a therapy clinic attached to a university in Canada. Clients who used this clinic were, on average, in their 30s and experiencing difficulties around anxiety, depression, relationships, and self-esteem, and received an average of 12 sessions of counselling, using a variety of therapeutic approaches. Reasons for termination, from the point of view of the counsellor, were identified on the basis of information held in the case files of 194 clients. Eighty-seven of these clients were then interviewed by telephone and asked to describe their own perception of why they left counselling. A comparison was made between counsellors' and clients' perspectives on reasons for terminating therapy.

Counsellors believed that around one-third of clients completed because they had achieved their goals, with most of the remainder stopping because of practical constraints such as moving house, lack of time or money, or referral to another service. Counsellors recorded fewer than 5 per cent of cases in which clients finished because of dissatisfaction with therapy. The picture that emerged from clients was quite different from the one presented by their therapists. Compared with their counsellors, a slightly higher proportion of clients (44 per cent) stated that they terminated counselling because they had achieved their goals. But a *much* higher proportion described themselves as dissatisfied. Around one in three told the interviewer that 'therapy was going nowhere', 'therapy did not fit my ideas about treatment', and they were 'not confident in my therapist's ability'. Nine per cent of these clients stated that 'therapy was making things worse'. The findings of Hunsley et al. (1999) are consistent with results from other research into this issue (Dale et al. 1998; Murdock et al. 2010; Westmacott et al. 2010).

Why does such a discrepancy arise? Research by Rennie (1994a, 1994b) and Blanchard and Farber (2016) suggests that clients show deference to their therapists, and refrain from telling them things they believe that the therapist might not want to hear. These studies have significant implications for practice. As therapy comes to an end, it is important for therapists to allow clients to be open about their disappointments, as well as to celebrate and reinforce their achievements. The possibility of being grateful to someone who has genuinely tried to help, yet being able to acknowledge openly to that person that their help has not made a difference, can be a significant learning experience in itself.

## Types of ending

There are many types of ending to a therapy. There may be a planned ending, where therapist and client decide together on when to end, and are able to devote time to working through the meaning of termination. One special type of ending is *referral* to another therapist or agency. Referral can occur after initial assessment, or may take place after several sessions of therapist. For example, in some counselling settings, clients may be allowed only a limited number of sessions (sometimes no more than six), and may need to be passed on to another therapy clinic or service once the limit has been reached. The experience of referral can be difficult for both therapist and client (Wood and Wood 1990). There are also traumatic or sudden endings, arising from the death or illness of the client or therapist, or other anticipated events such as the client going to jail. Therapists get other jobs, move elsewhere on training rotation, are made redundant, and get pregnant. A major category of ending consists of what are often described as 'unplanned' endings, where the client stops attending for no apparent reason.



## Unplanned endings

The existence of unplanned endings, or what are often described as ‘do not attend’ (DNA) clients, represents a major challenge for counsellors and psychotherapists. When a client does not attend, it means that at least one hour of therapist time has not been used productively (the hour when the client was expected, plus any additional sessions that are offered, as well as administrative time). This has important implications for waiting lists. It is probable that missed sessions, or walking away from therapy, will mean that the client does not benefit from the help that is on offer. The client may feel conflicted about not attending. They may worry that they have let the therapist down, or it may have been hard to make the decision to leave a therapy that has been disappointing or even harmful. A client not turning up for a session can be stressful for a therapist. There will be unanswerable questions about what has happened. The therapist may be worried about the client and there may be concerns about their own competence. The therapist or the therapy clinic may need to figure out what to do next – whether to contact the client, how to do this, and how many chances to give them.

Taken together, these factors mean that a great deal of research has been carried out into the phenomenon of client non-attendance, and many practical initiatives have been developed to reduce DNA rates. The issue of unplanned endings is not trivial. Reviews carried out into rates of non-attendance have found that on average between 20 per cent (Swift and Greenberg 2012) and 35 per cent (Roos and Werbart 2013) of clients drop out of therapy for one reason or another. Estimation of DNA rates is not straightforward, in that different organisations use different ways of defining its occurrence (Connell et al. 2006). DNA rates vary significantly across different clients and therapist characteristics. For example, dropout is higher among male clients, younger clients, and individuals with addictions, personality problems, or more severe symptoms (Saxon et al. 2010) and with low expectations for therapy (Zimmermann et al. 2017). Frayn (1992) examined the assessments carried out on 85 people who had applied for psychoanalysis or long-term psychoanalytic psychotherapy. About one-quarter of these clients were later to drop out of therapy prematurely. Compared with the clients who had remained in therapy, those who had terminated prematurely were less motivated, possessed lower levels of psychological-mindedness, and had a lower tolerance for frustration. In addition, at assessment the therapists had experienced more negative attitudes towards those clients who were later to leave early. In a meta-analysis of studies that had analysed dropout from cognitive behavioural therapy, Fernandez et al. (2015) found that on average 16 per cent dropped out before starting treatment and a further 26 per cent did so during treatment, with the highest rates associated with depressed clients and e-therapy interventions. Higher dropout rates have been found where client and therapist have different ethnic/cultural backgrounds (Presley and Day 2018).

There are also pronounced therapist and clinic effects, with some therapists and therapy centres reporting virtually zero DNA clients while others record high rates of such clients (Saxon et al. 2017; Xiao et al. 2017a, 2017b; Zimmermann et al. 2017). Therapist effects (i.e. differences in DNA rates for different therapists) do not appear to be associated with level of training or experience. Instead, they seem to be linked to more fundamental personal qualities and attitudes. Therapists who are not comfortable working with clients from a different cultural background to their own tend to report high rates of non-attendance with such clients (Owen et al. 2017). One study found that therapist facial expression of emotion was linked to dropout – therapists who were emotionally affirming were more likely to keep clients, while therapists who seemed tense were more likely to lose them (Luedke et al. 2017). In another study, dropout was influenced by the client’s first impression of the therapist (Beckham 1992). Interviews with clients who had dropped out of therapy in the IAPT service in NHS England, attributed their decision to the manner and personality of the therapist to whom they had been assigned, the rigidity of the organisation, long waiting times, and the experience of not having their expectations fulfilled (Marshall et al. 2016). Interviews with clients who had dropped out of a therapy service in Iran revealed similar themes (Khazaie et al. 2016).

It is important to recognise that clients walk away from therapy, without giving notice, for many reasons. In some instances, the client may feel that they have received sufficient benefit from therapy. In interviews with clients who did not attend therapy, Snape et al. (2003) found that many of them had not realised that they were expected to inform anyone that they were not planning to return. Nevertheless, the main reason why clients record unplanned endings is dissatisfaction with therapy. In some situations, where clients are receiving unhelpful or harmful therapy, the decision to drop out may constitute a vital means of self-protection.

The costs to therapy services of unplanned endings, along with the ethical requirement to offer treatment that matches a client's needs, has meant that many initiatives have been undertaken in different clinics to reduce the proportion of DNA clients. Because of the multiple factors that influence the act of dropping out of therapy, it is unlikely that any single strategy will have a major effect. Some reduction in DNA rates has been found in projects where client expectations regarding numbers of sessions have been explicitly addressed early in therapy (Swift and Callahan 2011), or clients have been routinely sent text message appointment reminders (Kravariti et al. 2018; McLean et al. 2016). In a survey of therapists, Westmacott and Hunsley (2017) observed that most therapists identified client DNA rates as a serious issue within their practice, and sought to reduce such cases by implementing strategies that included preparing clients for therapy, agreeing a treatment plan, working on maintaining a strong alliance, and using feedback tools. Additional widely used therapist strategies listed by Swift et al. (2012) include incorporating client preferences into therapy, and instilling positive expectations and hope.

## Practical strategies for managing endings

Therapists' training involves learning about the issues that may arise around the ending of therapy, and acquiring skills and strategies for dealing with this phase of the work. Some of the key principles of this part of practice are outlined in the following sections.

### Preparing to end

The ending of therapy is not a self-contained event – it always takes place in the context of what has gone before. From both ethical and practical perspectives, the start of therapy needs to include some sort of conversation and agreement about how long therapy will last. If there is no agreed fixed length, then there should be a discussion on how the decision to end will be made. The ethical principle of informed consent (Chapter 29) requires that such an agreement is made. There are also practical concerns, for both client and therapist, of personal circumstances that may have an influence on how many meetings are possible. For example, a trainee therapist may be rotated to another placement or internship after a certain number of weeks, or a client who is a university student may finish their course of study and move back home to another city. Often a therapist will initiate further conversations, at later sessions, around how many meetings remain or how many more sessions the client feels they need. If the therapy process involves the client completing a symptom or goals measure each session, the information obtained may make it apparent to the client or therapist that the client has either got what they came for or looks like never getting what they came for. Such evidence may trigger a conversation about the length of therapy. It can be valuable, from the start of therapy, to agree to conduct a review every few sessions (typically every six sessions). This means that the possibility of ending, or working towards an ending, is part of the on-going conversation between therapist and client, rather than being something that is dreaded or avoided (Etherington and Bridges 2011). There are other, subtle ways in which the possibility of ending may become salient. For example, 'natural' breaks such as holidays can function as 'trial endings'. At the first session following a vacation, some therapists explore with the client whether they had felt able to cope in the absence of the therapist (Răbu and Haavind 2012, 2018; Răbu et al. 2013a, 2013b).

## How therapists facilitate the process of ending

For a therapist, the process of facilitating a productive ending to the work with a client presents a number of challenges. Both client and therapist may be experiencing mixed feelings about the ending, and be aware of unfinished business and missed opportunities. There are also ethical and professional issues to be addressed to ensure client future well-being. A survey of therapists carried out by Norcross et al. (2017) found a high level of agreement across practitioners regarding the main tasks at this stage of therapy:

- explicit planning and preparation: inviting the client to think about their ending needs and preferences; working together to formulate a specific plan for ending; making arrangements around the possibility of client–therapist contact once therapy has ended;
- processing client and therapist feelings (both positive and negative);
- discussing how the client will cope in future – for example, identifying situations that might trigger relapse, and the circumstances under which a return to therapy might be beneficial;
- inviting the client to consider how they will apply new skills and insights beyond the end of therapy;
- conveying the message that personal learning and development is an on-going journey that is never completed;
- anticipating continued post-therapy growth, for example by encouraging ownership of accomplishments;
- communicating pride in the progress made by the client;
- saying goodbye.

There are many different ways in which these core ending tasks can be performed. Goode et al. (2017) describe a collaborative approach to ending, which emphasises increased mutuality and sharing as the final session is approached. From a functional analytic psychotherapy (FAP) perspective, Tsai et al. (2017) have outlined a list of client and therapist questions to be considered in a final session. For example, the therapist is invited to tell the client about: memorable ways in which the client has moved them; how they have grown as a result of their time with the client; and what they will remember about the client. From a narrative perspective, Lenz et al. (2012) published an account of a narrative therapy approach, in which the therapist facilitated an ending ceremony involving a client and other members of her family, during which each of them recounted their story about the meaning of the therapy that had been completed. The technique of the therapist writing a goodbye letter to the client, which can be consulted in future as a reminder and reinforcement of what was learned in therapy, has been adopted by many therapists (Walker et al. 2017).

## The impact of ending on the therapist

Therapists are affected by their clients, and may experience a sense of loss when a client leaves therapy, as well as other feelings such as relief or pleasure. A busy therapist may be called on to facilitate a client ending almost every week, and as a result may become distanced from such emotional reactions. Also, in interview studies and professional writing, therapists appear to have a tendency to downplay such emotions, and emphasise instead the constructive ways that they are able to cope with endings. There are three brief papers that capture the depth of feeling that therapists may sometimes experience around the ending of their work with a client. Bamford and Akhurst (2014) were able to capture the profound ways that some counsellors working with children empathically identified with the vulnerability of their clients, and were deeply affected by losing touch with them. These feelings persisted over an extended period of time, and were particularly acute in cases where

the connection with the client had been 'severed' by external factors. Kaplan (2014) wrote in great detail about his work with a young male client who died, and his painful experience of attending the client's funeral. Wilson and Sperlinger (2004) sensitively describe the feelings of therapists whose clients dropped out of therapy.

### Box 6.2: When therapy does not end

The contemporary counselling and psychotherapy literature is dominated by the idea that therapy should proceed on the assumption that it will end. Much therapy, particularly in publicly funded clinics, is organised around time-limited models of practice. Even in private practice, the assumption is that therapist and client will agree an appropriate ending at some stage. However, some therapy does not end. There are some clients who have been so damaged by adverse life experiences that they need ongoing therapeutic support to be able to have any kind of satisfactory quality of life. Friedlander et al. (2014) discuss the ways in which community-based therapy services can respond to the needs of such clients. Hamm and Leonhardt (2016) describe the process of therapy with a highly traumatised woman receiving lifetime therapy as part of her in-patient care. At the present time, there does not appear to be any research-based evidence regarding the proportion of clients who are receiving open-ended therapy. It seems highly likely that the demand for such therapy is much higher than can currently be provided for.

## Conclusions

Leaving therapy means different things for different clients. Successfully managing the process of ending is a task that draws on all the skills and self-awareness of therapists, and can have implications for the client far beyond the date of their final meeting with their therapist. In addition, the effective handling of the client's decision to end can have significant resource implications for therapy service providers. There exists a broad consensus across the counselling and psychotherapy community about the kinds of things that need to happen to ensure the best possible ending experiences for clients. There is also a limited, but growing, research literature around this set of issues.



### Topics for reflection and discussion

- 1 Identify a situation in which an important relationship in your own life has come to an end. How did you cope with this event, in terms of both your behaviour/actions and your emotions? What are the implications of that episode for how you might respond (or have responded) to the ending of therapy as a client? What are the implications for how you might respond (or have responded) to endings in the role of therapist?
- 2 Reflect on a period in your life during which you intentionally engaged in positive behaviour change or personal growth – either with the help of a therapist or through some other form of support. How much do you remember about what was most helpful for you during that period? Is there anything that might have been done to allow you to retain a clearer recollection of these positive experiences?
- 3 How serious do you think the problem of unplanned endings is, either within therapy as a whole or within a specific clinic or service with which you are familiar? What do you think would be the best way to ensure an optimal balance between planned and unplanned endings?

## Suggested further reading

Two influential, classic texts that offer valuable further discussion around the questions explored in the present chapter are: *Good Goodbyes: Knowing How to End in Psychotherapy and Psychoanalysis* (Novick and Novick 2006) and *Terminating Psychotherapy: A Clinician's Guide* (O'Donohue and Cucciare 2010).



# PART

# 2

## Conceptualising the practice of therapy

Part 1 of this book mapped out the common ground of therapy – the kinds of processes and activities that lie at the heart of any therapeutic experience. The chapters in Part 2 provide a series of introductions to different ways of understanding and delivering these experiences. One of the key characteristics of contemporary counselling and psychotherapy is the extent to which it embraces a wide range of theories and approaches. This diversity is both a strength and a weakness. It is a strength because it reflects creativity and resourcefulness, and a capacity to be responsive to the many competing ideas about mental health and healing that exist in society. But it can also be viewed as representing a degree of fragmentation and lack of coherence that can sometimes undermine the capacity of the therapy professions to work together.

The American counsellor-educator Sharon Cheston (2000) proposed a useful framework for making sense of the differences in emphasis between therapy approaches. She suggested that any therapist, group of therapists, or broader therapy theory or tradition operates on the basis of three guiding principles. First, it needs to be clear about the *way of being* that is adopted by the therapist – for example, the therapist's relationship style, level of collaboration, and degree of emotional engagement. Second, therapy practice needs to be informed by a *way of understanding* the client's problems, and how these problems can be addressed. Finally, a therapy approach includes a specific array of *ways of intervening*, in the form of skills, interventions, activities, and physical props.

The chapters that follow outline different configurations of ways of being, understanding, and intervening that can be found within current therapy practice. Each of the therapy theories, approaches, and traditions that are discussed is capable of producing powerful and life-changing experiences for clients. At the same time, each of them is capable of being unhelpful or even harmful for some clients.

The primary aim of these chapters is to offer sufficient entry points into the main ideas and methods used within each therapy approach, so that readers are in a position to follow and learn more about the ones that seem particularly relevant to their needs and interests as clients or therapists. Therapy approaches are shaped in complex ways by the social, cultural, and historical contexts from which they emerge and within which they are used. As a result, each chapter includes a sketch of relevant historical, philosophical, cultural, and research influences.





# Chapter

# 7

## The psychodynamic tradition

<b>Introduction</b>	<b>93</b>
<b>The origins of psychodynamic therapy: the work of Sigmund Freud</b>	<b>94</b>
The childhood origins of emotional problems	95
The importance of the unconscious	96
The concept of transference	97
The main therapeutic techniques used in psychodynamic therapy	97
<b>Building the psychodynamic tradition: key contributions</b>	<b>100</b>
The early pioneers	101
The Object Relations School	101
The concept of projective identification	103
The 'real' relationship	104
The British Independents: the importance of countertransference	104
The American post-Freudian tradition: ego psychology and self-theory	105
The European tradition	106
Attachment theory	106
<b>Brief psychodynamic therapy</b>	<b>110</b>
Psychodynamic-interpersonal therapy	111
Dynamic interpersonal therapy	113
Other forms of brief psychodynamic therapy	113
<b>Research into psychodynamic therapy</b>	<b>114</b>
<b>Conclusions</b>	<b>114</b>
<b>Topics for reflection and discussion</b>	<b>115</b>
<b>Suggested further reading</b>	<b>115</b>

### Introduction

The psychodynamic approach represents one of the major traditions within contemporary counselling and psychotherapy. Psychodynamic therapy places great emphasis on the therapist's ability to

use what happens in the immediate, unfolding relationship between client and therapist to explore the types of feelings and relationship dilemmas that have caused difficulties for the client in their everyday life. The aim of psychodynamic therapy is to help clients to achieve insight and understanding around how their problems have developed and how they are maintained, and then translate this insight into a mature capacity to cope with current and future difficulties. To enable this process to take place, the therapist needs to be able to offer the client an environment that is sufficiently secure and consistent to permit safe expression of painful or shameful fantasies, impulses, and memories that undermine the capacity to engage in close relationships.

Although psychodynamic therapy has its origins in the ideas of Sigmund Freud, current theory and practice goes far beyond Freud's initial formulation. Whereas Freud was convinced that repressed sexual wishes and memories lay at the root of the patient's problems, later generations of practitioners and theorists have developed a more social, relationship-oriented approach. Psychodynamic methods have been applied to understanding and treating a wide range of problems, and have been adapted to a variety of ways of working, including brief therapy, group therapy, marital/couples counselling, and on-line therapy.

The aim of this chapter is to introduce some of the main ideas and methods involved in the theory and practice of psychodynamic counselling and psychotherapy. The chapter begins with an account of Freud's ideas. Freud remains a key point of reference for the majority of psychodynamic therapists and psychotherapists, and later developments in psychodynamic therapy can all be viewed as an ongoing debate with Freud – sometimes disagreeing markedly with his positions, but always returning to his core ideas. Subsequent sections in the chapter review the significance of object relations, attachment theory, and other important themes in psychodynamic theory and practice. Limitations of space make it difficult to do justice to the richness and resourcefulness of the psychodynamic contribution to therapy theory and practice: suggestions for further reading are provided within each section and at the end of the chapter.

## **The origins of psychodynamic therapy: the work of Sigmund Freud**

Sigmund Freud (1856–1939) is widely regarded as being not only one of the founders of modern psychology, but also a key influence on Western society in the twentieth century. As a boy Freud had ambitions to be a famous scientist, and he originally trained in medicine, becoming in the 1880s one of the first medical researchers to investigate the properties of the newly discovered coca leaf (cocaine). However, anti-Semitism in Austrian middle-class society at that time meant that he was unable to continue his career at the University of Vienna, and he was forced to enter private practice in the field that would now be known as psychiatry. Freud spent a year in Paris studying with the most eminent psychiatrist of the time, Charcot, who taught him the technique of hypnosis. Returning to Vienna, Freud began seeing patients who were emotionally disturbed, many of them suffering from what was known as 'hysteria'. He found that hypnosis was not particularly effective for him as a treatment technique, and gradually evolved his own method, called 'free association', which consisted of getting the patient to lie in a relaxed position (usually on a couch) and to 'say whatever comes to mind'. The stream-of-consciousness material that emerged from this procedure often included strong emotions, deeply buried memories and childhood sexual experiences, and the opportunity to share these feelings and memories appeared to be helpful for patients. One of them, Anna O., labelled this method 'the talking cure'. Further information about the development of Freud's ideas, and the influence on his thought of his own early family life, his Jewishness, his medical training, and the general cultural setting of late nineteenth-century Vienna, can be found in a number of books and articles (Gay 1988; Jacobs 1992; Langman 1997; Wollheim 1971).

Freud's method of treatment was called psychoanalysis. From the moment his theory and method became known and used by others (starting around 1900), his ideas have been continually modified and developed by other writers on and practitioners of psychoanalysis. As a result, there are now many therapists and psychotherapists who would see themselves as working within the broad tradition initiated by Freud, but who would call themselves *psychodynamic* in orientation rather than psychoanalytic. Therapists working in a psychodynamic way with clients all tend to make similar kinds of assumptions about the nature of the client's problems, and the manner in which these problems can best be worked on. The main distinctive features of both psychoanalysis and the psychodynamic approach are:

- an assumption that the client's difficulties have their ultimate origins in childhood experiences;
- an assumption that the client may not be consciously aware of the true motives or impulses behind their actions;
- the use in counselling and therapy of interpretation of the transference relationship.

These features will now be examined in more detail.

## The childhood origins of emotional problems

Freud noted that, during 'free association', many of his patients reported remembering unpleasant or fearful sexual experiences in childhood, and, moreover, that the act of telling someone else about these experiences was therapeutic. Freud could not believe that these childhood sexual traumas had actually occurred (although today we might disagree), and made sense of this phenomenon by suggesting that what had really happened had its roots in the child's own sexual needs.

It is important to be clear here about what Freud meant by 'sexual'. In his original writing, in German, he used a concept that might more accurately be translated as 'life force' or, more generally, 'emotional energy' (Bettelheim 1983). Although this concept has a sexual connotation to it, it is unfortunate that its English translation focuses only on this aspect.

Freud surmised, from listening to his patients talk about their lives, that the sexual energy – or libido – of the child develops or matures through a number of distinct phases. In the first year of life, the child experiences an almost erotic pleasure from its mouth, its oral region. Babies get satisfaction from sucking, biting, and swallowing. Then, between about two and four years of age, the child receives pleasure from defecating, from feelings in their anal region. Then, at around five to eight years of age, the child begins to have a kind of immature genital longing, which is directed at members of the opposite sex. Freud called this the phallic stage. (Freud thought that the child's sexuality became less important in older childhood, and he called this the latency stage.)

The phases of psycho-sexual development set the stage for a series of conflicts between the child and its environment, its family, and – most important of all – its parents. Freud saw the parents or family as having to respond to the child's needs and impulses, and he argued that the way in which the parents responded had a powerful influence on the later personality of the child. Mainly, the parents or family could respond in a way that was too controlling or one that was not controlling enough. For example, little babies cry when they are hungry. If the mother feeds the baby immediately every time, or even feeds before the demand has been made, the baby may learn, at a deep emotional level, that it does not need to do anything to be taken care of. It may grow up believing, deep down, that there exists a perfect world and it will become a person who finds it hard to accept the inevitable frustrations of the real world. On the other hand, if the baby has to wait too long to be fed, it may learn that the world only meets its needs if it gets angry or verbally aggressive. Somewhere in between these two extremes is what the British psychoanalyst D. W. Winnicott (1964) has called the 'good enough' mother, the mother or caretaker who responds quickly enough without being over-protective or smothering.

Freud suggested a similar type of pattern for the anal stage. If the child's potty training is too rigid and harsh, it will learn that it must never allow itself to make a mess, and may grow up finding

it difficult to express emotions and with an obsessive need to keep everything in its proper place. If the potty training is too permissive, on the other hand, the child may grow up without the capacity to keep things in order.

The third developmental stage, the phallic stage, is possibly the most significant in terms of its effects on later life. Freud argued that the child at this stage begins to feel primitive genital impulses, which are directed at the most obvious target: its opposite-sex parent. Thus at this stage, little girls are 'in love' with their fathers and little boys with their mothers. But, Freud went on, the child then fears the punishment or anger of the same-sex parent if this sexual longing is expressed in behaviour. The child is then forced to repress its sexual feelings, and also to defuse its rivalry with the same-sex parent by identifying more strongly with that parent. Usually, this 'family drama' would be acted out at a largely unconscious level. The effect later on, in adulthood, might be that people continue to repress or distort their sexuality, and that in their sexual relationships (e.g. marriage) they might be unconsciously seeking the opposite-sex parents they never had. The basic psychological problem here, as with the other stages, lies in the fact that the person's impulses or drives are 'driven underground', thus influencing them unconsciously. Thus, someone might not be consciously aware of having 'chosen' a marriage partner who symbolically represents their mother or father, but their behaviour towards the partner may follow the same pattern as the earlier parent-child relationship. An example of this might be the husband who as a child was always criticised by his mother, and who later on seems always to expect his wife to behave in the same way.

It may be apparent from the previous discussion that, although Freud in his original theory emphasised the psycho-sexual nature of childhood development, what really influences a child emotionally and psychologically as they grow up is the quality of the relationships they have with their parents and family. This realisation has led more recent writers in the psychodynamic tradition, notably Erik Erikson (1950) and John Bowlby (1969, 1973, 1980, 1988), to emphasise the psycho-social development of the child rather than the sexual and biological aspects. However, although the psychodynamic tradition has moved away from Freud's focus on sexuality in childhood, the basic viewpoint that is shared by all psychoanalytic and psychodynamic counsellors and therapists is that to understand the personality of an adult client or patient, it is necessary to understand the development of that personality through childhood, particularly with respect to how it has been shaped by its family environment.

## The importance of the unconscious

Freud did not merely suggest that childhood experiences influence adult personality; he also suggested that the influence occurred in a particular way – through the operation of the unconscious mind. The 'unconscious', for Freud, was the part of the mental life of a person that was outside direct awareness. Freud saw the human mind as divided into three regions:

- The id ('it'), a reservoir of primitive instincts and impulses that are the ultimate motives for our behaviour. Freud assumed that there were two core drives: life/love/sex/Eros and death/hate/aggression/Thanatos. The id has no time dimension, so that memories trapped there through repression can be as powerful as when the repressed event first occurred. The id is governed by the 'pleasure principle', and is irrational.
- The ego ('I'), the conscious, rational part of the mind, which makes decisions and deals with external reality.
- The superego ('above I'), the 'conscience', the store-house of rules and taboos about what you should and should not do. The attitudes a person has in the superego are mainly an internalisation of their parents' attitudes.

There are two very important implications of this theory of how the mind works. First, the id and most of the superego were seen by Freud as being largely unconscious, so that much of an individual's behaviour could be understood as being under the control of forces (e.g. repressed memories,

childhood fantasies) that the person cannot consciously acknowledge. The psychodynamic counselor or therapist, therefore, is always looking for ways of getting ‘beneath the surface’ of what the client or patient is saying – the assumption being that what the person initially says about themselves is only part of the story, and probably not the most interesting part.

Second, the ego and the other regions (the id and superego) are, potentially at any rate, in constant conflict with one another. For example, the id presses for its primitive impulses to be acted upon (‘I hate him so I want to hit him’) but the ego will know that such behaviour would be punished by the external world, and the superego tries to make the person feel guilty because what they want to do is wrong or immoral. It is, however, highly uncomfortable to live with such a degree of inner turmoil, and so Freud argued that the mind develops defence mechanisms – for example, repression, denial, reaction formation, sublimation, intellectualisation, and projection – to protect the ego from such pressure. So, not only is what the person consciously believes only part of the story, it is also likely to be a part that is distorted by the operation of defence mechanisms.

## The concept of transference

The concept of transference represents a fundamental cornerstone of psychodynamic theory and practice. Freud discovered that as soon as he began to encourage his patients to express whatever it was that they were thinking and feeling (free association), their view of him was not based on an objective or rational response to his actual behaviour and demeanour. Instead, they developed strong positive or negative feelings about him that had no apparent basis in reality. What he soon realised was that it was as if his patients were perceiving him through a lens or filter constructed from previous relationships in their lives. They were experiencing him as if he was a harsh father, or loving mother, or seductive governess, or whatever mix of significant early attachments had shaped their way of being with other people. He also began to appreciate that this process occurs in everyday life (someone immediately falls in love with a person they know nothing about, or feels like a little child when their boss speaks to them), but is less readily detected because so much else is happening within a relationship. By contrast, the unique environment of the therapy relationship, in which the therapist remains rigorously neutral, allows these underlying ways of being with others gradually to come into focus.

Within psychodynamic theory, the general everyday manifestations of distortions in the ways in which people relate to each other are discussed under the heading of *defence mechanisms*. Within the setting of the therapy relationship, the same phenomena are described as *transference*. The concept of transference can be defined as comprising both the conscious and unconscious responses of the patient to the therapist (Maroda 2004) and as a mix of positive and negative reactions to the therapist (Gomez 1997). For example, the therapist may be viewed as a loving, nurturing figure, or as withholding, critical, and cruel.

Over the years, psychodynamic therapy has consistently moved in the direction of regarding the exploration of transference reactions (and the *countertransference* response of the therapist) as a central component of the therapeutic endeavour. If the client can arrive at a point of displaying what they really feel for the therapist (whether that be love, hate, or anything else), then the stage is set for a re-enactment of the original scenarios that laid down their basic emotional attitudes towards other people. The task of the therapist, when these critical moments arise, is to ‘behave differently from the original characters in the patient’s life drama’ (Maroda 2004: 4). If this happens, the client begins to become aware of new and different possibilities around relationships with others.

## The main therapeutic techniques used in psychodynamic therapy

The theoretical ideas introduced in the previous sections originally emerged out of the work of Freud and others on helping people with emotional problems. Freud used the phrase ‘where id was,



let ego be' to summarise the aims of psychoanalysis. In other words, rather than being driven by unconscious forces and impulses, people after therapy will be more rational, more aware of their inner emotional life, and more able to control these feelings in an appropriate manner. A key aim of psychoanalysis is, then, the achievement of *insight* into the true nature of one's problems, such as their childhood origins and how they are expressed in everyday relationships. But genuine insight is not merely an intellectual exercise – when the person truly understands, they will experience a release of the emotional tension associated with the repressed or buried memories. Freud used the term 'catharsis' to describe this emotional release.

### Box 7.1: The mechanisms of defence

Anna Freud, the youngest child of Sigmund Freud, trained as a psychoanalyst and went on to be one of the pioneers of child analysis. Anna Freud also made a major theoretical contribution to psychoanalysis by elaborating and refining her father's ideas about the role of *defence mechanisms*. This increasing attention to the ways in which the ego defends itself against emotionally threatening unconscious impulses and wishes represents an important step away from the original biologically oriented psychoanalytic 'drive' theory, in the direction of an 'ego' psychology that gave more emphasis to cognitive processes. The key defence mechanisms described by Anna Freud (1936/1966) in her book *The Ego and the Mechanisms of Defense* included:

- *Repression* (motivated forgetting): the instant removal from awareness of any threatening impulse, idea, or memory.
- *Denial* (motivated negation): blocking of external events and information from awareness.
- *Projection* (displacement outwards): attributing to another person one's own unacceptable desires or thoughts.
- *Displacement* (redirection of impulses): channelling impulses (typically aggressive ones) on to a different target.
- *Reaction formation* (asserting the opposite): defending against unacceptable impulses by turning them into the opposite.
- *Sublimation* (finding an acceptable substitute): transforming an impulse into a more socially acceptable form of behaviour.
- *Regression* (developmental retreat): responding to internal feelings triggered by an external threat by reverting to 'child-like' behaviour from an earlier stage of development.

Although it may often be straightforward to identify these kinds of patterns of behaviour in people who seek therapy (and in everyday life), it is less clear just how best a therapist might respond to such defences. Is it best to draw the client's attention to the fact that they are using a defence mechanism? Is it more effective to attempt gently to help the person to put into words the difficult feelings that are being defended against? Is it useful to offer an interpretation of how the defensive pattern arose in the person's life, and the role it plays? Or is it better to respond in the 'here-and-now', perhaps by reflecting on how the therapist feels when, for example, certain assumptions are projected on to them? From a psychodynamic perspective, many issues and choices are involved in knowing how to use an awareness of the mechanisms of defence in the interests of the client. The writings of the British analyst David Malan (1979) provide an invaluable guide to ways of using the interpretation of defences to help clients to develop insight and, eventually, more satisfying relationships.

A number of therapeutic techniques or strategies are used in psychoanalytic or psychodynamic therapy. These include:

- 1** *Deliberate and systematic use of the relationship between the therapist and client.* Psychodynamic counsellors and psychotherapists tend to behave towards their clients in a neutral manner. It is unusual for psychodynamically trained therapists to share much of their own feelings or own lives with their clients. The reason for this is that the therapist is attempting to present themselves as a 'blank screen' on to which the client may project their fantasies or deeply held assumptions about close relationships.
- 2** *Disciplined use of therapist self-awareness or 'countertransference'.* The feelings, emotions, fantasies, and action tendencies (e.g. wanting to touch the client, or wanting to run away from them) that the therapist experiences in response to a client are considered valuable information about the inner life of the client, their everyday way of being with others, and the quality of the client–therapist relationship. For example, if the therapist feels irritated with the client, then it is likely that other people may have similar responses to them.
- 3** *Maintaining a secure and consistent therapeutic structure or 'frame'.* If the client is to be able to 'regress' back into suppressed early memories and feeling states, then they need to feel safe enough to do so. One of the ways that this is achieved is to maintain a high level of consistency around the time and place of therapy, how the room is laid out, where each person sits, and the behaviour of the therapist. The existence of well-defined boundaries also makes it possible to make sense of violations to the boundary, such as the client being late for a session, as an expression of a hidden conflict.
- 4** *Identifying and analysing resistances and defences.* As the client talks about their problem, the therapist may notice that they are avoiding, distorting, or defending against certain feelings or insights. Freud saw it as important to understand the source of such resistance, and would draw the patient's attention to it if it happened persistently. For example, a student seeing a therapist for help with study problems, who then persistently blames tutors for their difficulties, is probably avoiding their own feelings of inadequacy, or dependency, by employing the defence mechanism of projection (i.e. attributing to others characteristics you cannot accept in yourself).
- 5** *Expression of emotion.* It is assumed that emotions represent the energy for living that is available to the person. In addition, emotions express the truth of a person's relationships with others. By contrast, cognitive and intellectualised ways of talking are likely to reflect an avoidance of emotional truth. Psychodynamic therapists recognise that it is hard for clients to express emotions, particularly areas of feeling that have been repressed or forbidden in the past. An important aspect of psychodynamic technique therefore involves the development of a 'feeling language' through which the client can begin to talk about their emotions.
- 6** *Free association or 'saying whatever comes to mind'.* The intention is to help the person to talk about themselves in a fashion that is less likely to be influenced by defence mechanisms. It is as though in free association the person's 'truth' can slip out.
- 7** *Working with dreams and fantasies.* Freud saw the dream as 'the royal road to the unconscious', and encouraged his patients to tell him about their dreams. Again the purpose is to examine material that comes from a deeper, less defended, level of the individual's personality. It is assumed that events in dreams symbolically represent people, impulses, or situations in the dreamer's waking life. Other products of the imagination – such as waking dreams, fantasies, and images – can be used in the same way as night dreams as material for exploration and analysis.
- 8** *Interpretation.* A psychoanalytic counsellor or therapist will use the processes described above – transference, dreams, free association, etc. – to generate material for interpretation. Through interpreting the meaning of dreams, memories, and transference, the therapist is attempting to help clients to understand the origins of their problems, and thereby gain more control over

them and more freedom to behave differently. However, effective interpretation is a difficult skill. Some of the issues that the counsellor or therapist must bear in mind when making an interpretation are:

- Is the timing right? Is the client ready to take this idea on board?
  - Is the interpretation correct? Has enough evidence been gathered?
  - Can the interpretation be phrased in such a way that the client will understand it?
- 9 *Other miscellaneous techniques.* When working with children as clients, it is unrealistic to expect them to be able to put their inner conflicts into words. As a result, most child analysts use toys and play to allow the child to externalise their fears and worries. Some therapists working with adults also find it helpful to use expressive techniques, such as art, sculpture, and poetry. The use of projective techniques, such as the Rorschach Inkblot Test or the Thematic Apperception Test (TAT), can also serve a similar function. Finally, some psychodynamic therapists may encourage their clients to write diaries or autobiographies as a means of exploring their past or present circumstances.

In addition to counsellors and psychotherapists who have received specialist training in psychodynamic ways of working, it is probably true to say that virtually all therapists have been influenced at some level by psychoanalytic ideas: the influence on therapy in general of psychoanalysis and the psychodynamic tradition has been immense.



### **Case study 7.1: Psychodynamic therapy in practice: A boy who had been sexually abused**

A valuable and deeply moving account of the process of psychodynamic therapy can be found in a case study by Prior (2012), where he describes his work with Thomas, an 8-year-old boy who had been sexually abused. In contrast to work with adult clients, where communication is dominated by words, the age of this client makes it easier to observe how emotion was conveyed through actions that had the effect of triggering specific states of feeling in the therapist. Thomas dealt with his anger and confusion by becoming a 'moving target' – never stopping long enough in one place to allow anyone else to appreciate what he was experiencing. A crucial aspect of the therapy was Thomas's anger with the therapist, which lasted for several months. Prior (2012) understood this anger as arising from the fact that he represented, for Thomas, things that were too hard to talk about. Nevertheless, he was still affected by it, and only arrived at an emotional understanding of this process when a memory of a long-forgotten childhood experience of personal rejection emerged in his own awareness. Eventually, therapy became a safe enough place. Thomas and his therapist found ways to slow down, and to put his experiences into words. This case demonstrates how psychodynamic therapy is an intensely personal and spontaneous meeting between two individuals, each of whom has their own vulnerabilities, in which the therapist draws on theory to make it possible to make sense of, and tolerate, client behaviour that may be experienced as challenging and confusing.

## **Building the psychodynamic tradition: key contributions**

Psychoanalysis and psychodynamic therapy have been around for a long time: there have been many opportunities for psychodynamic therapists and theorists with new ideas to develop distinct approaches within the broad umbrella of the psychodynamic community, or to offer new ways

of making sense of key concepts and methods. The following sections offer an overview of how a specific therapy model – psychoanalysis – became gradually transformed into a broad therapy tradition (psychodynamic). Although the various sources of influence are discussed in a linear, chronological fashion, it is important to keep in mind that they interacted with each other in many complex ways, and that psychodynamic therapy continues to change and grow in response to new challenges.

## The early pioneers

It is well documented that Freud demanded a high level of agreement with his ideas from those around him. During his lifetime, several important figures in psychoanalysis who had been his students or close colleagues were involved in disputes with Freud and subsequently left the International Association for Psycho-Analysis. The most influential of these figures has been Carl Jung. Other important figures within this phase of the development of psychodynamic therapy include Sandor Ferenczi, Otto Rank, Wilhelm Reich, and Alfred Adler.

The Jungian approach, also known as *analytic psychology*, was created by C. G. Jung (1875–1961), a Swiss psychiatrist who was initially very close to Freud and then split with him in 1912 through disagreement over theoretical differences. In particular, Jung diverged from the Freudian position on the predominance of sexual motives in the unconscious. Jung developed a concept of the ‘collective unconscious’, which he saw as structured through ‘archetypes’, symbolic representations of universal facets of human experience, such as the mother, the trickster, the hero. Perhaps the best known of the Jungian archetypes is the ‘shadow’, or animus (in women) or anima (in men), which represents those aspects of the self that are denied to conscious awareness. Another difference between Freud and Jung was highlighted in their views on development. Freudian thinking on development is restricted largely to events in childhood, particularly the oral, anal, and Oedipal stages. Jung, on the other hand, saw human development as a lifelong quest for fulfilment, which he called ‘individuation’. Jung also evolved a system for understanding personality differences, in which people can be categorised as ‘types’ made up of sensation/intuition, extraversion/introversion, and thinking/feeling. Jung was also highly influenced by religious and spiritual teachings, whereas Freud was committed to a more secular, scientific approach. The most accessible of Jung’s writings are his autobiography, *Memories, Dreams, Reflections* (Jung 1963), and *Man and His Symbols* (Jung 1964).

## The Object Relations School

The ‘object relations’ approach to psychoanalysis and psychodynamic counselling and psychotherapy is a relationship-oriented approach to therapy (Gomez 1997) that has been influenced by studies based on direct observation of the behaviour of babies and infants, and mother–infant interaction.

The originator of the object relations movement within the psychodynamic approach is usually accepted to be Melanie Klein. Born in Austria, Klein trained with a student of Freud, Sandor Ferenczi, in Hungary, and eventually moved to Britain in 1926, becoming an influential member of the British Psycho-Analytical Society. The work of Klein was distinctive in that she carried out psychoanalysis with children, and placed emphasis on the relationship between mother and child in the very first months of life, whereas Freud was mainly concerned with the dynamics of Oedipal conflicts, which occurred much later in childhood. For Klein, the quality of the relationship that the child experienced with human ‘objects’ (such as the mother) in the first year set a pattern of relating that persisted through adult life. The original writings of Klein are difficult, but H. Segal (1964), J. Segal (1985, 1992), and Sayers (1991) present readable accounts of her life and work.

Before Klein, very few psychoanalysts had worked directly with children. Using drawings, toys, dolls, and other play materials, Klein found that she was able to explore the inner world of the child, and discovered that the conflicts and anxieties felt by children largely arose not from their sexual impulses, as Freud had assumed, but from their relationships with adults. The relationship with

the mother, in particular, was a centrally important factor. A young child, in fact, cannot survive without a caretaker, usually a mother. Another child psychoanalyst working within this tradition, D. W. Winnicott (1964), wrote that 'there is no such thing as a baby', pointing out that 'a baby cannot exist alone, but is essentially part of a relationship'.

From the point of view of the baby, according to Klein, the mother in the first months is represented by the 'part-object' of the breast, and is experienced as either a 'good object' or a 'bad object'. She is 'good' when the needs of the baby are being met through feeding; she is 'bad' when these needs are not being met. The baby responds to the bad object with feelings of destructive rage. The first few months are described by Klein as a 'paranoid-schizoid' period, when the baby feels very little security in the world and is recovering from the trauma of birth. Over time, however, the baby begins to be able to perceive the mother as a more realistic whole object rather than as the part-object of the breast, and to understand that good and bad can co-exist in the same person. The early phase of splitting of experience into 'good' and 'bad' begins to be resolved.

The next phase of development, according to Klein, is characterised by a 'depressive' reaction, a deep sense of disappointment and anger that a loved person can be bad as well as good. In the earlier phase, the baby was able to maintain the fantasy of the 'good mother' as existing separate from the 'bad'. Now they must accept that the bad and the good go together. There is a primitive sense of loss and separation now that the possibility of complete fusion with the 'good' mother has been left behind. There may be a sense of guilt that it was the child themselves who was responsible for the end of the earlier, simpler, phase of the relationship with the mother.

It is essential to recognise that the infant is not consciously aware of these processes as they happen. The awareness of the child is seen as dream-like and fragmented rather than logical and connected. Indeed, it is hard for adults to imagine what the inner life of a child might be like. In her effort to reconstruct this inner life, Klein portrays a world dominated by strong impulses and emotions in response to the actions of external 'objects'. The assumption is that the emotional inner world of the adult is built upon the foundations of experience of these earliest months and years.

One of the key characteristics of this inner world, according to the object relations perspective (and other theories of child development, such as that of Piaget), is the inability of the child to differentiate between what is self and what is the rest of the world. In the beginning, the child is egocentric in the sense that it believes it has power over everything that happens in its world; for example, that food arrives because I cry, it is morning because I wake up, or granddad died because I did not take care of him. It is this 'self-centredness', which may become expressed in grandiose or narcissistic patterns of relating to others, that forms the underlying cause of many of the problems that the person may encounter in adult life.

Klein's ideas represented a subtle but highly significant shift in psychoanalytic thinking. Rather than focusing their attention primarily on the operation of biological/libidinal impulses, Klein and her colleagues were beginning to take seriously the quality of the *relationships* between the client/patient and others. Object relations theorists adopted the term 'object' in acknowledgement of the fact that the person's emotionally significant relationships could be with an actual person, with an internalised image or memory of a person with *parts* of a person (for example, the mother's breast), or with a physical object such as a teddy or security blanket. The use of the term 'object' also implies that the client may be relating to another person not in a 'real' or 'authentic' way, but in a way that is selective or objectifying.

One of the most fundamental of the dysfunctional patterns by which people relate to 'objects' is *splitting*. The idea of splitting refers to a way of defending against difficult feelings and impulses that can be traced back to the very first months of life. Klein, it will be recalled, understood that babies could only differentiate between the wholly 'good' and wholly 'bad' part-object of the breast. This object was experienced by the baby as one associated with pleasurable and blissful feelings while feeding, or with feelings of rage when it was absent or taken away. Correspondingly, the psychological and emotional world of the baby at this very early stage



consisted only of things that were good or bad; there were no shades of feelings in between. The fundamental insecurity and terror evoked by the feelings of 'bad' led Klein to characterise this as a 'paranoid-schizoid' position.

As the child grows and develops, it becomes able to perceive that good and bad can go together, and therefore it can begin to distinguish different degrees of goodness and badness. When this development does not proceed in a satisfactory manner, or when some external threat re-evokes the insecurity of these early months, the person may either grow up with a tendency to experience the world as 'split' between objects which are all good or all bad, or use this defence in particular situations.

For the psychodynamic therapist, the client who exhibits splitting is defending against feelings of love and hate for the same object. For example, a woman who idealises her therapist and complains repeatedly in therapy of the misdeeds and insensitivity of her husband, may have underlying strong feelings of longing for closeness in the marriage and rage at the way he abuses her, or an underlying need to be taken care of by him coupled with anger at his absences at work. As with the other defences described earlier in the chapter, the task of the therapist is first of all to help the client to be aware of the way she is avoiding her true feelings through this manoeuvre, then gently to encourage exploration and understanding of the emotions and impulses that are so hard to accept. From a psychodynamic perspective, the reason why the person needs to use the defence is that some aspects of the current situation are similar to painful childhood situations, and are bringing to the surface long buried memories of early events. Although the client may be a socially and professionally successful and responsible adult, the inner emotional turmoil she brings to therapy is the part of her that is still a child, and only has available to it infantile ways of coping, such as splitting. So, in the case of the woman who idealises her therapist and scorns her husband, it may eventually emerge that, perhaps, the grandfather who was supposed to look after her when Mum was out actually abused her sexually, and she could only deal with this by constructing a 'good' granddad object and a 'bad' one.

## The concept of projective identification

The defence mechanism of splitting is similar to the classic Freudian ideas of defence, such as repression, denial, and reaction formation, in that these are all processes that occur within the individual psyche or personality. The Kleinian notion of *projective identification*, however, represents an important departure, in that it describes a process of emotional defence that is interpersonal rather than purely intrapersonal. Being able to apply the idea of projective identification is therefore a uniquely valuable strategy for psychodynamic therapists who view client problems as rooted in relationships.

The concept of 'projection' has already been introduced as a process whereby the person defends against threatening and unacceptable feelings and impulses by acting as though these feelings and impulses only existed in other people, not in the person themselves. For example, a man who accuses his work colleagues of always disagreeing with his very reasonable proposals may be projecting on to them his own buried hostility and competitiveness. The therapist who persists in assuming that a depressed client really needs to make more friends and join some clubs may be projecting her own fear of her personal inner emptiness. *Projective identification* occurs when the person to whom the feelings and impulses are being projected is manipulated into believing that they have these feelings and impulses. For instance, the man who accuses his colleagues may unconsciously set up circumstances where they have little choice but to argue with him – for example, by not explaining his ideas with enough clarity. And the therapist may easily persuade the depressed client that she herself does want to make friends.

From an object relations perspective, the dynamics of projective identification have their origins in very early experience, in the time when the child was unable to tell the difference between self and external objects. In projective identification, this blurring of the self–other boundary is



accompanied by a need to control the other, which comes from the early state of childhood grandiose omnipotence. Cashdan (1988) has identified four major patterns of projective identification, arising from underlying issues, with relationships, of dependency, power, sexuality, and ingratiating. In the case of dependency, the person will actively seek assistance from other people who are around by using phrases such as 'What do you think?' or 'I can't seem to manage this on my own'. The person is presenting a relationship stance of helplessness. Usually, however, these requests for help are not based on a real inability to solve problems or cope, but are motivated by what Cashdan (1988) calls a 'projective fantasy', a sense of self-in-representation originating in disturbed object relations in early childhood.

The idea of projective identification provides psychodynamic therapists with a useful conceptual tool for disentangling the complex web of feelings and fantasies that exist in troubled relationships. The unconscious intention behind projective identification is to induce or entice the other to behave towards the self as if the self was in reality a dependent, powerful, sexual, or helpful person. This interpersonal strategy enables the person to deny that the dependency, for example, is a fantasy which conceals behind it a multiplicity of feelings, such as resentment, longing, or despair. There may be times when the projection is acceptable to the person on the receiving end, perhaps because it feeds their fantasy of being powerful or caring. But there will be times when the recipient becomes aware that there is something not quite right, and resists the projection. Or there may be times when the projector themselves becomes painfully aware of what is happening. Finally, there may be occasions in therapy when projective identification is applied to the therapist, who will be pressured to treat the client in line with fantasy expectations.

## The 'real' relationship

An important aspect of the object relations approach with the psychodynamic tradition has been its acknowledgement of the possibility of a 'real' client-therapist relationship that exists beyond transference and countertransference. The Scottish psychoanalyst Ronald Fairbairn (1889–1964), one of the leading figures in the development of an object relations approach, was particularly interested in the difficulties that many of his patients had in making 'real' contact either with him or with anyone else in their lives. He came to describe the inner worlds of such patients as 'closed systems'. He described the aim of psychoanalysis as that of breaking through the closed system of the patient's inner world, in order to allow the person to become 'accessible to the influence of outer reality' (Fairbairn 1958: 380).

Fairbairn pointed out that the idea of 'transference' implied a process taking place within a closed system. By contrast, if a person was able to make genuine contact with another (e.g. their therapist), then they would treat that other person as a unique individual, and no transference would occur. Fairbairn's ideas reflected an enormous shift in psychoanalytic practice, the significance of which can too easily be lost in the abstract language used by the majority of psychodynamic/psychoanalytic theorists. It is clear that what Fairbairn is referring to is an *active* therapist, who is seeking to move beyond transference and use a 'real' relationship to 'breach' the closed system of the client's inner world. This perspective made it possible for later generations of psychodynamic counsellors and psychotherapists to move beyond the 'blank screen' approach inherent in the Freudian model, and evolve a different style of psychodynamically informed therapy.

## The British Independents: the importance of countertransference

The origins of the British 'Independent' group can be traced back to the beginnings of psychoanalysis in Britain. The British Psycho-Analytical Society was formed in 1919, under the leadership of Ernest Jones. In 1926, Melanie Klein, who had been trained in Berlin, moved to London and became a member of the British Society. From the beginning Klein was critical of conventional psychoanalysis. She pioneered child analysis, insisted on the primary importance of destructive urges and the

death instinct, and paid more attention to early development than to Oedipal issues. The contrast between the views of Klein and her followers, and those of more orthodox Freudians, came to a climax with the emigration of Freud and his daughter Anna Freud, along with several other analysts from Vienna, to London in 1938. Anna Freud represented the mainstream of Freudian theory, and in the years immediately following the death of Freud in 1939, the relationship between her group and the Kleinians became tense. In the 1940s, there were a series of what came to be known as 'controversial discussions' in the Society (Rayner 1990).

In what can be seen as a reflection of the British capacity for compromise, the Society decided by 1946 to divide, for purposes of training, into three loose groups: the Kleinians, the Anna Freud group, and the 'middle' group, who later became known as the Independents. The rule was introduced that analysts in training must be exposed to the ideas and methods of more than one group. This principle has resulted in a tradition of openness to new ideas within the British psychodynamic community (Kohon 1986).

Although the Independents generated new ideas across the whole span of psychodynamic theory (Rayner 1990), the group is known in particular for its reappraisal of the concept of *countertransference*. Previously, countertransference had been regarded with some suspicion by analysts, as evidence of neurotic conflicts in the analyst. By contrast, Heimann (1950), Symington (1983), and other Independents argued that countertransference was one of the most important tools in analysis, because it represented a vital source of information that could feed in to the therapist's understanding of the client. The approach to countertransference initiated by the Independents also involved a warmer, more personal or authentic contact between client and therapist (Casement 1985, 1990), and anticipated many of the developments associated with time-limited psychodynamic therapy.

## The American post-Freudian tradition: ego psychology and self-theory

The development in Britain, by Klein, Fairbairn, and others, of an object relations approach that emphasised the importance of the client's relationships, rather than their libido-based drives, was matched in the USA by the writings of Margaret Mahler, Heinz Kohut, and their colleagues, who were beginning to follow a similar line.

The strand of recent psychoanalytic thinking represented by the work of Kohut (1971, 1977) and Kernberg (1976, 1984) is generally referred to as 'self' theory, and is based in a re-evaluation of the phenomenon of narcissism within. The concept of narcissism was originally introduced by Freud, who drew upon the Greek legend of Narcissus, a youth who fell in love with his own reflection. Freud viewed over-absorption in self as a difficult condition to treat through psychoanalysis, since it was almost impossible for the analyst to break through the narcissism to reach the underlying conflicts. Kohut (1971) argued that the narcissistic person is fundamentally unable to differentiate between self and other. Rather than being able to act towards others as separate entities, in narcissism other people are experienced as 'self objects' – as little more than extensions of the self. Other people only exist to aggrandise and glorify the self. For Kohut, the solution to this lay in the transference relationship between client and therapist. If the therapist refrained from directly confronting the falseness and grandiosity of the client, and instead empathised with and accepted the client's experience of things, a situation would be created that paralleled the conditions of early childhood.

Kohut (1971) argued that, just as the real mother is never perfect, and can only hope to be 'good enough', the therapist can never achieve complete empathy and acceptance. The client therefore experiences, at moments of failure of empathy, a sense of 'optimal frustration'. It is this combination of frustration in a context of high acceptance and warmth that gradually enables the client to appreciate the separation of self and other. These ideas have made a significant contribution to psychodynamic theory and practice. A related area of advance has been in work with clients diagnosed as 'borderline personality disorder' (Kernberg 1975, 1984).

## Box 7.2: The influence of D. W. Winnicott

One of the key figures in the development of psychodynamic therapy has been D. W. Winnicott (1896–1971). Born into an upper-class family in Plymouth, Donald Winnicott trained in medicine and specialised in paediatrics, and used his early professional experience in working with children as the basis of many of his most influential contributions to psychoanalysis. Winnicott described the therapy relationship as providing a ‘holding environment’ within which the client could feel safe to examine painful experiences. He observed that it was necessary for any child to have a ‘good enough’ mother in order to thrive emotionally, and was the first to describe the existence of ‘transitional objects’ – blankets, toys, and other items that unconsciously functioned to remind the child, when away from the mother, of the security of the parental relationship. Winnicott also introduced the distinction between the ‘true self’ (the core of the personality) and the ‘false self’ (the mask that adapts to the demands of others). Winnicott’s concept of the true/false self had an impact on the thinking of many other important theorists, such as Eric Berne and R. D. Laing. For Winnicott, the ideal form of therapy was one in which he could help the client to enter a state of playfulness, as a means of re-evoking positive childhood experience: the work of the therapist is directed towards bringing the client from a state of not being able to play into a state of being able to play.

Key books by Winnicott include: *The Child, the Family and the Outside World* (1964), *The Maturation Processes and the Facilitating Environment* (1965), and *The Piggle: An Account of the Psychoanalytic Treatment of a Little Girl* (1977). Excellent biographical accounts of his life and work have been published by Jacobs (1995), Phillips (2007), and Rodman (2003).

## The European tradition

There exists an important European tradition in psychoanalytic psychotherapy. Psychodynamic and psychoanalytic approaches either dominate therapy provision, or are highly influential, in Germany, Sweden, France, and other European countries. The German tradition is unusual in the respect to which psychodynamic therapy is available for patients with psychosomatic disorders. The majority of these patients are treated on an inpatient basis – Germany is unique in having a significant number of inpatient psychotherapy beds (Kachele et al. 1999). The generosity of the German healthcare system is also reflected in the number of sessions of publicly funded psychodynamic therapy that are available to patients. German, Swedish, Danish, and Norwegian researchers have been responsible for a substantial proportion of studies of psychoanalytic therapy.

The development of psychoanalysis in France has followed a different pathway. The French analyst Jacques Lacan (1901–1981) drew heavily on concepts from philosophy and linguistics, as well as advocating a return to what he perceived to be some of the basic ideas of Freud. Lacan (1977, 1979) placed a great deal of emphasis on the concept of *desire*, and the categorisation of consciousness into three modes of apprehending the world: the *imaginary*, the *symbolic*, and the *real*. For Lacan, the task of therapy was to use language (the symbolic) to bridge the gap between two fundamentally non-linguistic realms: the imaginary and the real. Lacan also advocated innovations in technique, such as the use of short sessions. A key theme in Lacanian theory is the limits of an understanding that is based solely on language; much of his work explores the limitations of language.

## Attachment theory

The ideas of the British psychoanalyst John Bowlby (1969, 1973, 1980, 1988) have become increasingly influential within psychodynamic therapy and psychotherapy in recent years. Although trained

as an analyst, Bowlby was also an active researcher. The main focus of his work was around the process of *attachment* in human relations. In his research and writing, Bowlby argued that human beings, like other animals, have a basic need to form attachments with others throughout life, and will not function well unless such attachments are available. The capacity for attachment is, according to Bowlby, innate, but is shaped by early experience with significant others. For example, if the child's mother is absent, or does not form a secure and reliable bond, then the child will grow up with a lack of trust and a general inability to form stable, close relationships. If, on the other hand, the mother or other family members have provided the child with what Bowlby calls a 'secure base' in childhood, then later close relationships will be possible.

Similarly, according to Bowlby, early experiences of loss can set an emotional pattern that persists into adulthood. Bowlby and colleagues (1952) observed that children separated from their parents – for example, through hospitalisation – initially respond through protest and anger, then with depression and sadness, and finally by behaving apparently normally. This normality, however, masks a reserve and unwillingness to share affection with new people. If the parents return, there will be reactions of rejection and avoidance before they are accepted again. For the young child, who is unable to understand at a cognitive level what is happening, this kind of experience of loss may instil a fear of abandonment that makes them either cling on to relationships in later life or even avoid any relationship that might end in loss or abandonment. For the older child, the way they are (or are not) helped to deal with feelings of grief and loss will likewise set up patterns that will persist. For example, when parents divorce, it is quite common for a child to end up believing that they caused the split and subsequent loss, and that consequently they are a 'bad' person who would have a destructive impact on any relationship. Such a person might then find it hard to commit to relationships later in their life.

Bowlby (1973) suggested that the person develops an 'internal working model' to describe their internal representation of the social world, their main attachment figures within that world, themselves, and the links between these elements. It can be seen that the idea of the 'internal working model' is similar to the notion of internalised 'object relations' used by Klein and Fairbairn and other 'object relations' theorists. There were, however, three important differences in emphasis between Bowlby and the object relations theorists. First, he argued that a biologically based mechanism of attachment had a central part to play in the inner life of the person. Second, he always maintained that attachments were the result of actual behaviour by another person (i.e. not solely internal). Third, Bowlby strongly believed that evidence from scientific research was just as important as insight derived from clinical practice.

Inspired by Bowlby, researchers in different parts of the world have sought to develop deeper understandings of the way that attachment operates, and how this idea can be applied in therapy. The most important lines of research are associated with the work of Mary Ainsworth, Mary Main, and Peter Fonagy.

With the aim of looking more closely at attachment behaviour in young children, Mary Ainsworth carried out a series of studies using the 'strange situation' procedure (Ainsworth et al. 1978; Bretherton and Waters 1985). The 'strange situation' is a laboratory laid out like a playroom, where infants can be systematically observed from behind a mirror while the mother twice leaves, and then returns. The behaviour of infants in this situation has been shown to be similar to their behaviour in real-life (home) situations when they are left alone. Infant responses can be categorised into four types.

- 1 *Secure*. The child shows signs of missing the parent, then seeks contact when she returns and settles back into playing normally.
- 2 *Insecure-avoidant*. The infant shows few signs of missing the parent, and avoids her upon reunion.
- 3 *Insecure-ambivalent*. The child is highly distressed and angry when the parent leaves, and cannot be settled when she returns.
- 4 *Insecure-disoriented*. The child shows a range of stereotyped and frozen patterns of behaviour.

Ainsworth found that the behaviour of infants in the strange situation experiment could be explained by the behaviour of their mothers. For example, 'secure' children had mothers who were sensitive to their emotional signals, whereas 'insecure' children had mothers who could be observed to be insensitive, rejecting, or unpredictable.

Although Ainsworth's research provided a convincing picture of the powerful nature of attachment patterns in early childhood, it is not possible to observe adult patterns in such a clear-cut manner in a laboratory experiment. Mary Main therefore developed the *Adult Attachment Interview* (AAI) as a means of assessing patterns of attachment later in life (Hesse 1999; Main 1991). The AAI consists of a 15-item clinical interview, which will normally take around two hours to complete. The questions asked in the interview are intended to 'surprise the unconscious'. In other words, the person will find themselves saying things, or contradicting themselves, in ways that are beyond their conscious control. For participants, the interview is similar to a therapy session, in that they are invited to talk openly, and at length, about childhood experiences and memories that may be quite painful. Analysis of the interview depends less on the content of what the person says, but is largely derived from the style or manner in which the person tells the story of their early life.

Coding of the AAI yields four types of attachment pattern that are broadly similar to the categories used in the 'strange situation' test:

- *Secure/autonomous*. The person's story is coherent, consistent, and objective. They are able to collaborate with the interviewer.
- *Dismissive*. The story is not coherent. The person tends to be dismissive of attachment-related experiences and relationships. There is a tendency to describe parents as 'normal' or ideal.
- *Preoccupied*. The story is incoherent, and the speaker may appear angry, passive, or fearful, and preoccupied with past relationships. Sentences are often long, vague, and confusing.
- *Unresolved/disorganised*. Similar to dismissive or preoccupied, but may include long silences or overtly erroneous statements (for example, talking as though someone who died is still alive).

A substantial amount of research has been carried out using the AAI, and has found strong correlations between the attachment styles of parents and their children, and differences in the process of therapy with people exhibiting different attachment styles (Hesse 1999).

From the point of view of therapy practice, one of the most significant aspects of research using the AAI was the discovery by Mary Main that people who had experienced secure attachments, and who functioned well in their lives, were able to talk about their past in a coherent and collaborative way. Main suggested that 'securely attached' people are able to do this because they are able to engage in 'metacognitive monitoring': they are able to 'step back' from the situation and reflect on what they are saying. This capacity to look objectively at one's own thought processes is only possible, according to Main and other AAI researchers, because the person has been able to develop a coherent 'internal working model' of self in relationship. Peter Fonagy and his colleagues have teased out the implications of Main's notion of metacognitive monitoring for the practice of counselling and psychotherapy. Fonagy (1999) argues that it is mentalisation, the capacity to learn how to *reflect* on experience, that lies at the heart of effective therapy. The development within therapy of what Fonagy calls the 'reflexive function', the ability to think about and talk about painful past events, helps the person to protect themselves against the raw emotional impact of these events, without having to use defences such as denial or repression.

Bowlby's ideas on attachment have not resulted in the creation of a specific 'attachment therapy'. Instead, an attachment perspective has permeated psychodynamic counselling and psychotherapy in a variety of different ways. These influences have been reviewed by Berry and Danquah (2016; Burke et al. 2016) and Gelso et al. (2013), who identified two main ways in which therapists tend to



use attachment ideas. First, knowledge of attachment theory helps practitioners to become more aware of the possible origins of patterns of relationships described by their clients, which then allows them to adapt their approach in response to the attachment style of the client. Second, therapists are aware of, and make use of, the potential for the therapy relationship to become an internalised 'secure base' for the client, from which they can begin to build more satisfying relationships in their everyday life (Geller and Farber 2015). For many therapists, an appreciation of how these processes operate in therapy practice has been greatly facilitated by accessing the writings of the British psychodynamic therapist Jeremy Holmes (2000, 2001, 2015).

Other important developments within attachment theory include research into the biological mechanisms associated with different patterns of attachment behaviour (Rustin 2013; Schore 2001, 2019; Schore and Schore 2008). Attachment theory has also found applications in education and child care, for example through the 'circle of security' model (Mercer 2015), and in psychotherapeutic work with children and families (Diamond 2014).

### Box 7.3: Critical perspectives on attachment theory

Although attachment theory is backed up by considerable research evidence, and has been influential in many areas of life beyond psychotherapy, it is nevertheless important to acknowledge some of its limitations. The assumption that attachment patterns in adults are necessarily based in early childhood experience is challenged by studies that demonstrate the existence of 'earned security' – the capacity of people to acquire secure attachments through family and friendship relationships with alternative support figures at later stages of life (Saunders et al. 2011). This perspective is reinforced by the work of Harris (2009), who has showed that adult personality is more likely to reflect peer group influences (e.g. school friends) than to be based on emotional learning in early years interactions with mum and dad. From a feminist stance, Knudson-Martin (2012) has argued that attachment theory does not take sufficient account of gender roles and power in relationships. Male power, domination, and control undermine the trust that provides the foundation for secure relationships. For example, in a marriage, relationship difficulties may be attributable to gender roles rather than attachment patterns.

### Box 7.4: The concept of mentalisation

The concept of *mentalisation* refers to a process of implicitly or explicitly interpreting the actions of others as meaningful in terms of the operation of intentional mental states (states of mind, desires, needs, feelings, reasons) (Allen and Fonagy 2006; Fonagy et al. 2002). It can be regarded as a form of imaginative activity, because it involves imagining what another person might be thinking or feeling. A reduced capacity to engage in mentalisation has been found to be characteristic of individuals suffering from severe forms of psychological difficulties, such as borderline personality disorder (Fonagy and Bateman 2006; Fonagy and Target 2006). In the absence of mentalisation, it is very hard for a person to develop satisfactory relationships with other people – they never really understand why these people behave in the way they do (and may not even understand their own personal responses to others). It is difficult for such a person to reflect on action, and it is therefore almost impossible for them to benefit from any form of psychotherapeutic process that relies on reflection.



### Box 7.5: The concept of the 'third'

Thinking in terms of 'threes' represents an important principle of psychodynamic practice. In his earliest writings, Freud suggested that many of the emotional problems that people experience in adult life can be traced back to the interplay between the Oedipal threesome of child, mother, and father. Malan (1979) and other therapists used the idea of 'triangular' relationships to inform their use of transference interpretation. For example, the relationship between the client and therapist could be influenced by the client's relationship with authority figures from earlier periods in their life, or could replicate the dynamics of their relationship with their current husband, wife, or partner. Pointing out these links to the client, in the form of interpretation, can lead to insight and change. What makes this helpful? Britton (1989) suggested that it is helpful because the early experience of relating to two parents, and accommodating conflicting emotions (such as love and hate) provides a person with an essential capacity for seeing themselves in interaction with others and an ability to grasp another point of view while retaining one's own perspective. Benjamin (2004) has drawn out the implications of this idea, in arguing that awareness that there can be a 'third' point of view is an essential element of the process of learning about relationships. 'Thirddness' is a subtle and elusive concept that offers a valuable means of making sense of the nature of human consciousness (Coelho Junior 2016). When a person is in contact with someone else, it is as though there is always someone else present. For example, when a therapist makes a theoretical interpretation, it implies the presence of an 'other' who formulated the theory, or others from whom the therapist learned the theory.

## Brief psychodynamic therapy

Although it has come to be viewed as a form of long-term therapy, Freud and his colleagues did not necessarily assume that patients needed to be in treatment for long periods of time. For example, in 1908, Freud carried out successful therapy of a sexual problem in the composer Gustav Mahler over the course of four sessions (Jones 1955). More recently, there have been several initiatives around the most effective ways to offer psychodynamic therapy on a time-limited basis (Davanloo 1980; Malan 1976, 1979; Mann 1973; Sifneos 1979).

Writers on brief psychodynamic therapy have different ideas about what they mean by 'brief', which can refer to anything between three and 40 sessions, though most would agree that brief treatment involves fewer than 25 sessions. More fundamental, however, is the idea that the number of sessions is rationed, and that a contract is made at the start of therapy that there will only be a certain number of sessions.

Brief psychodynamic counselling or psychotherapy typically commences with an assessment interview that explores the readiness and capability of the client to engage productively in this kind of therapy. A principal task in early sessions is to find a focus for the overall therapy, and for each particular session. The therapist actively seeks a focus for the work, and in this respect differs from the traditional psychoanalyst who would wait for themes to emerge through free association. The existence of a definite date after which therapy will no longer be available raises a whole range of potential issues for clients. For instance, the ending of therapy may awaken feelings associated with other kinds of endings, and lead the client to act out in the relationship with the therapist the ways they have defended against previous feelings of loss. The role of the therapist in brief psychodynamic work is therefore subtly different from that in traditional psychoanalysis. In the latter, the therapist takes a passive role, acting as a 'blank screen' on to which may be projected the transference reactions of the client. In brief work, by contrast, the therapist is active and purposeful, engaging the client in a therapeutic alliance in which they can work together.

In long-term analysis, the therapist encourages the development of a strong transference reaction, sometimes called a 'transference neurosis', in order to allow evidence of childhood relationship patterns to emerge. In brief work, strategies are used to avoid such deep levels of transference – for example, by identifying and interpreting transferences as soon as they arise, even in the very first session, and by reducing client dependency by explaining what is happening and maintaining a clear focus for the work. In brief therapy, the here-and-now feeling response of the client towards the therapist, the transference, is used instead as the basis for making links between present behaviour with the therapist and past behaviour with parents (Malan 1976).

It can be seen here that the basic techniques of psychoanalysis – working with transference, affect, and interpretation – are used in brief psychodynamic work, but with important modifications. The preceding paragraphs have offered a broad introduction to some general principles of brief psychodynamic therapy (see also Binder and Betan 2013). Contemporary training, practice, and research in this area are largely organised around a set of specific models of brief psychodynamic therapy, each of which packages up these general principles in a slightly different way. Introductory outlines of some of the most widely used of these models are provided next.

## Psychodynamic-interpersonal therapy

A significant development within the psychodynamic community in Britain has been the evolution of what was originally described as the *conversational* model, but more recently has been termed a *psychodynamic-interpersonal* approach. This version of psychodynamic therapy was initially developed in Britain by Bob Hobson and Russell Meares (Hobson 1985). The distinctive feature of the conversational model is that it is based on contemporary ideas about the meaning and role of language that are quite different from the assumptions and concepts of mainstream psychodynamic theory. It is an approach that has been highly innovative in the areas of theory, service delivery, and research. In addition, there has been careful attention around how best to train people in this approach (Goldberg et al. 1984; Mackay et al. 2001; Maguire et al. 1984).

The seminal text for the conversational/psychodynamic-interpersonal model is *Forms of Feeling: The Heart of Psychotherapy* by Hobson (1985). This is an unusual and creative book, in which Hobson draws on lengthy case descriptions and makes frequent use of literary sources. It is clear from the way the book is written that Hobson is presenting the approach not as an abstract theoretical or intellectual system, but as a set of principles that can help to focus the task of constructing what he terms the 'special friendship' that is therapy. It also appears as though Hobson is unwilling to present the theory as a fixed and definitive set of ideas. Tentativeness and uncertainty are highly valued. Knowledge and understanding are to be achieved through dialogue rather than by authoritative assertion. A more recent textbook, which incorporates current research evidence into the processes and outcomes of PI, is *Psychodynamic-Interpersonal Therapy: A Conversational Model*, by Barkham et al. (2017).

At the core of the approach is the idea that people need to be able to talk about their feelings. The troubles that people bring to therapy stem from an inability to engage in dialogue with others around their feelings. The dialogue or conversation is crucial to well-being because it is through conversation that a person can act on feelings (language is a form of action; words 'do things'), and because the dialogue with another person dissolves the loneliness that is associated with holding feelings to oneself – for example, grieving in isolation. A primary task of the therapist or psychotherapist is to develop a mutual 'feeling language' through which client and therapist can conduct a conversation about how the client feels. The therapist does this by paying attention to the actual or implicit feeling words and metaphors employed by the client.

The therapist intentionally uses both 'I' and 'we' statements as a way of communicating the presence of another person, and extending an invitation to dialogue. Here, the therapist eschews neutrality and 'owns' what they say to the client, and through this way of talking hopes to act as a model for the client, thereby encouraging the client to 'own' their feelings too. The therapist suggests tentative hypotheses that suggest possible links between the feelings of the client and the events or

relationships in their life. All of this is built around the idea of the mutual conversation. The client has a 'problem' because in that area of their life they are unable to engage in a mutual conversation with anyone. Therapy offers the chance to open up such a mutual conversation, with the possibility that it might extend after therapy into other relationships.

The effectiveness of psychodynamic-interpersonal therapy has been confirmed in several research studies (Barkham et al. 2017; Shapiro et al. 1994). In particular, studies have been undertaken of the usefulness of this way of working with clients who are usually considered to be difficult to help, such as people who deliberately self-harm (Guthrie et al. 2001) and those with longstanding mental health problems (Davenport et al. 2000; Guthrie et al. 1998, 1999) or physical symptoms that have not responded to medical treatment (Guthrie 1991).



### **Case study 7.2: 'I can't keep it in . . . my guts are churning': psychodynamic conversations about bowel problems**

Irritable bowel syndrome (IBS) is a condition that consists of abdominal pain and distension, and altered bowel habits, in the absence of any identifiable underlying organic cause. Many of those suffering from IBS respond well to medical treatment, but about 15 per cent are not helped by drugs or dietary regimes. It seems likely that the problems of many of these 'refractory' IBS patients are psychosomatic in nature, and that therapy may be of value to them. Guthrie (1991) carried out a study of the effectiveness of psychodynamic-interpersonal therapy with 102 hospital outpatients diagnosed as having refractory IBS. Half of the patients received therapy, which comprised one long (3–4 hour) initial session, followed by six sessions of 45 minutes spread over the following 12 weeks. The other half were allocated to a control group, and met with the therapist on five occasions over the same period of time to discuss their symptoms, but without receiving active therapy interventions. The results of the study demonstrated the effectiveness of psychodynamic-interpersonal therapy with this group of people.

The account of one case described by Guthrie (1991) offers an illustration of the way that psychodynamic-interpersonal therapy operates in practice. The client, Bob, was 49 and had suffered from abdominal pain and loose motions for several years. He had been unable to work for the previous three years. Bob was an only child, brought up by a 'strict and unaffectionate' mother; his father had left home when he was six. He saw himself as a 'loner', and he was far from convinced that therapy could help him. He spoke for a long time in the first session about his symptoms:

'My guts are always churning.'

'I can't work, I always have to keep rushing to the loo.'

'It's awful, everything just explodes away from me.'

'I just have to go, it's awful, I'm frightened to go out.'

The therapist did little more than feed back his words:

'Can't keep things in.'

'When things come out . . . no control.'

'Frightened . . . no control . . . awful . . . just have to go.'

Gradually, in therapy, Bob came to realise that the same words he was using to describe bowel symptoms, were those his therapist was using to talk about Bob's feelings. Making this connection made it possible for him to talk more freely about himself. He described in some depth how

humiliated he felt by his first wife, who had particularly belittled his sexual performance, and how dominated he had felt by his mother. At one point, his therapist tentatively enquired whether he was worried she would humiliate him in some way. At this point he suddenly got up and rushed out of the room saying he had to go to the toilet.

Over the following sessions, Bob became more able to see his bowel symptoms as a metaphor for how he felt inside. As a result of making this connection, he began to talk to his wife about his fear, and his symptoms improved. Soon, he was able to return to work, even though his symptoms had not completely disappeared.

The case of Bob captures the way that the psychodynamic-interpersonal approach works. The therapist engages in a conversation around whatever is most meaningful for the client, in this instance bowel symptoms. The therapist and client develop a mutual feeling language and, through being able to use this language, the client is enabled to stop avoiding what is difficult or painful in their life. The therapist is tentative, yet direct and personal.

## Dynamic interpersonal therapy

Dynamic interpersonal therapy (DIT) is a form of brief (16-session) psychodynamic therapy that has been developed for the treatment of depression in the context of the Improving Access to Psychological Therapies (IAPT) programme within the National Health Service in England (Lemma et al. 2011b, 2013), and has subsequently been adopted by other services (Chen et al. 2017; Douglas et al. 2016). The protocol for this form of therapy was based on a review of research evidence and competency statements for brief psychodynamic therapy as a whole (Lemma et al. 2008). Candidates for training in DIT are required to possess extensive prior theoretical and practical knowledge and experience in psychodynamic therapy, and to have undergone their own personal therapy. The delivery of DIT is based on a manual (Lemma et al. 2011a) that outlines therapists' activities and tasks at the start, middle phase, and end of therapy.

The change process in DIT is envisaged as starting with the identification of a core problem (such as loss or negative childhood events) that appears to underpin the client's pattern of depression. Attachment dimensions and feeling states associated with that problem are explored, with the aim of enabling the client to mentalise or reflect productively on their experience. The client is then helped to consider other ways of feeling and thinking in situations that evoke depression. Finally, at the end of therapy the client is provided with a written statement by the therapist, summarising their work together, as a means of preventing future relapse. Throughout this process, the therapist uses the here-and-now transference relationship as a source of information and insight in respect of more general relationship difficulties that the client is experiencing in everyday settings.

Qualitative interviews with clients after the end of therapy have indicated that most of them found DIT to be valuable, and described learning processes that were consistent with the DIT model (Leonidaki et al. 2016, 2018). One of the striking findings to emerge from these interviews was the sense the client had that therapy represented only the beginning of a change process that they were committed to carrying forward in all areas of their life. However, some clients struggled to come to terms with time limits, or stated that they would have preferred a more solution-oriented approach. Further development of DIT has involved the use of this model in therapy for individuals with medically unexplained somatic symptoms (Delfstra and van Rooij 2015).

## Other forms of brief psychodynamic therapy

There are several other well-established approaches to brief psychodynamic therapy that are similar to psychodynamic-interpersonal and dynamic interpersonal therapy. Time-limited dynamic psychotherapy (Levenson 2003, 2006, 2017; Levenson and Strupp 2007) emerged from the work of Hans

Strupp and his colleagues, and focuses in particular on helping the client to change cyclical maladaptive patterns of relating to others. Intensive short-term dynamic psychotherapy (Abbass and Town 2013) builds on the ideas of the psychoanalyst Habib Davanloo, and advocates a process of ‘unlocking the unconscious’ by challenging the ways in which the client defends themselves against difficult emotions. Affect phobia therapy (Donovan et al. 2016; McCullough 2003) is a brief dynamic approach that pays particular attention to the ways in which repressed emotions are expressed in non-verbal behaviour and body awareness. Accelerated experiential dynamic psychotherapy (Fosha 2000) takes a broadly comparable perspective. Other initiatives have involved the delivery of brief psychodynamic therapy through the internet (Johansson et al. 2012, 2013) and self-help reading materials (Frederick 2009).

## Research into psychodynamic therapy

Despite Freud’s somewhat negative attitude to research – he believed that the only way to understand psychoanalysis was to participate in it – there exists an extensive research literature on all aspects of psychoanalysis and psychodynamic therapy. References to relevant studies are provided throughout the present chapter. Reviews of research into the effectiveness of psychodynamic therapy can be found in Kivlighan et al. (2015) and Shedler (2010). Overall, these reviews provide solid evidence for the effectiveness of psychodynamic therapy for a wide range of presenting problems. Many studies have also investigated the aspects of the process of psychodynamic therapy, such as transference, countertransference, attachment, and interpretation. These studies have a lot of practical value, because researchers are forced to find ways to define and observe complex and ambiguous processes that may, in the original psychoanalytic literature, be embedded in vague clinical descriptions and abstruse debates. An example of an area where research has brought enhanced clarity to therapy practice has been the use of transference interpretation. Studies by Luborsky and Crits-Christoph (1990; Luborsky et al. 1992, 1994) and Ulberg et al. (2014) have made a major contribution to clarifying the differences between helpful and unhelpful therapist interpretations of what is happening in the here-and-now relationship with the client.

An important development within research into psychodynamic therapy in recent years has been the growing number of qualitative studies in which clients have been interviewed about their experience of this form of therapy (e.g. Bury et al. 2007; Haskayne et al. 2014; Leonidaki et al. 2016, 2018; Lilliengren and Werbart 2005; Nilsson et al. 2007; Poulsen et al. 2010; Roe et al. 2006; Toto-Moriarty 2013). A recurring theme across these studies is that, while most clients who have been interviewed acknowledge that psychodynamic therapy has been helpful and worthwhile for them, many also report frustration regarding how long it took for them to grasp the meaning and value of what was happening in sessions. In addition, a minority clearly indicate that they would have preferred a more practical, problem-solving approach.

## Conclusions

Psychoanalysis has provided a set of concepts and methods that have found application in a wide variety of contexts. Psychodynamic ideas have proved invaluable not only in individual therapy and counselling, but also in groupwork, couples therapy, and the analysis of organisations (see later chapters). The ideas of Freud have been robust and resilient enough to withstand critique and reformulation from a number of sources. Psychodynamic perspectives have made a significant contribution to research into the process of counselling and psychotherapy. Throughout this book there are many examples of the ways psychodynamic ideas have been used in different contexts and settings. All counsellors and therapists, even those who espouse different theoretical models, have

been influenced by psychodynamic thinking and have had to make up their minds whether to accept or reject the Freudian image of the person.



## Topics for reflection and discussion

- 1 Strupp (1972: 276) has suggested that the psychodynamic therapist or psychotherapist 'uses the vantage point of the parental position as a power base from which to effect changes in the patient's interpersonal strategies in accordance with the principle that *in the final analysis the patient changes out of love for the therapist*'. Do you agree?
- 2 To what extent does time-limited therapy distort or undermine the distinctive aims and meaning of psychodynamic work?
- 3 Think about your relationship with someone you have found difficult to deal with at an interpersonal level. Make some brief notes about what happened, and what was difficult about your contact with this person. Analyse what you have written about this relationship in psychodynamic terms, using concepts such as transference, countertransference, and mechanisms of defence. What were the psychodynamic processes occurring in this person, and in you, that made this relationship problematic? In what ways might the psychodynamic perspective on what happened help you to deal with a similar situation in the future?

## Suggested further reading

Anyone who is seriously interested in making sense of what psychodynamic therapy is really about needs to read some of Freud's original writings, rather than rely on second-hand textbook accounts. Freud was a wonderfully vivid and persuasive writer, who inexorably draws the reader into his search for psychoanalytic truth. A good place to start might be the *Five Lectures on Psycho-Analysis* (Freud 1910/1963), first delivered at Clark University in Massachusetts in 1909. Here, Freud was trying to explain his ideas to an enthusiastic, but also sceptical, audience of American psychologists and psychiatrists. Beyond the *Five Lectures*, it is worth looking at one of the classic case studies – Dora, the Rat Man, the Wolf Man, Schreber – all of which are included in the widely available *Standard Edition of Freud's Works* (1976).

The literature on psychodynamic therapy is so wide and varied that it is not easy to recommend specific books without generating an endless list. An accessible, jargon-free introduction to contemporary psychodynamic thought can be found in *That Was Then, This Is Now: Psychoanalytic Psychotherapy for the Rest of Us* by Jonathan Shedler (2006; available at <http://psychsystems.net/shedler.html>). Gomez (1997), Jacobs (2017), and Spurling (2017) provide easy-to-read introductions to this approach. The journals *Psychodynamic Practice* and the *British Journal of Psychotherapy* contain stimulating combinations of clinical material, theoretical papers, and research articles that reflect the broad scope of psychodynamic work. Books that communicate the spirit of contemporary psychodynamic thought are *On Learning from the Patient* by Patrick Casement (1985), *Mothering Psychoanalysis* by Janet Sayers (1991), *Cultivating Intuition* by Peter Lomas (1994), *Psychodynamic Techniques: Working with Emotion in the Therapeutic Relationship* by Karen Maroda (2010), and *The Examined Life: How We Lose and Find Ourselves* by Stephen Grosz (2013).



# The cognitive–behavioural perspective

<b>Introduction</b>	<b>117</b>
<b>The origins and development of the cognitive–behavioural approach</b>	<b>117</b>
Applying behavioural concepts and methods in therapy	118
Systematic desensitisation and exposure	120
The limitations of a purely behavioural perspective	121
<b>The emergence of cognitive approaches to therapy</b>	<b>121</b>
<b>The practice of cognitive–behavioural therapy</b>	<b>124</b>
The therapeutic relationship: establishing rapport and creating a working alliance	125
Assessment: identifying and quantifying problem behaviours and cognitions	126
Case formulation: arriving at an agreed conceptualisation of the origins and maintenance of current problems	127
Intervention strategies: the application of cognitive and behavioural techniques	128
Monitoring: ongoing assessment of target behaviours	131
Relapse prevention: termination and planned follow-up	132
<b>Research into the effectiveness of CBT</b>	<b>133</b>
<b>Critical issues in CBT theory and practice</b>	<b>133</b>
<b>The third wave: the flourishing of CBT</b>	<b>134</b>
Dialectical behaviour therapy	135
Acceptance and commitment therapy	135
Motivational interviewing	136
Mindfulness-based cognitive therapy	137
Other third-wave approaches	137
Reflections on third-wave CBT	139
<b>Conclusions</b>	<b>140</b>
<b>Topics for reflection and discussion</b>	<b>140</b>
<b>Suggested further reading</b>	<b>141</b>

## Introduction

Cognitive–behavioural therapy (CBT) is currently the intervention model most likely to be offered to clients within healthcare systems in North America, Europe, and other parts of the world. With its intellectual roots in behavioural psychology, CBT has three key features: a problem-solving, change-focused approach to working with clients; a respect for scientific values; and close attention to the cognitive processes through which people monitor and control their behaviour. Cognitive Behavioural Therapy has achieved substantial cultural impact, through self-help books and a strong internet presence, and has become a global brand. The success of CBT has been based on the capacity of the CBT professional community to use research in creative and constructive ways to evaluate innovative techniques and new ideas, particularly around how to adapt its principles to meet the needs of different client groups.

This chapter begins by examining the origins of CBT in academic behavioural and cognitive psychology, then moves on to explore the specific concepts and methods associated with this important and influential approach to counselling and psychotherapy.

## The origins and development of the cognitive–behavioural approach

Ultimately, the cognitive–behavioural approach to therapy has its origins in behavioural psychology, which is widely seen as having been created by J. B. Watson, particularly through the publication in 1919 of *Psychology from the Standpoint of a Behaviorist*. Watson was a psychology professor at the University of Chicago at a time when psychology as an academic discipline was in its infancy. It had only been in 1879 that Wilhelm Wundt, at the University of Leipzig, had first established psychology as a field of study separate from philosophy and physiology. The method of research into psychological topics – such as memory, learning, problem-solving, and perception – that Wundt, Titchener, and others had used was a technique known as ‘introspection’, which involved research subjects reporting on their own internal thought processes as they engaged in remembering, learning, or any other psychological activity. This technique tended to yield contradictory data, since different subjects in different laboratories reported quite dissimilar internal events when carrying out the same mental tasks. The weakness of introspection as a scientific method, argued Watson, was that it was not open to objective scrutiny. Only the actual subject could ‘see’ what was happening, and this would inevitably result in bias and subjective distortion. Watson made the case that, if psychology was to become a truly scientific discipline, it would need to concern itself only with observable events and phenomena. He suggested that psychology should define itself as the scientific study of actual, overt behaviour rather than invisible thoughts and images, because these behaviours could be controlled and measured in laboratory settings.

Watson’s ‘behavioural’ manifesto convinced many of his colleagues, particularly in the USA, and for the next 30 years mainstream academic psychology was dominated by the ideas of the Behavioural School. The main task that behaviourists like Guthrie, Spence, and Skinner set themselves was to discover the ‘laws of learning’. They took the position that all the habits and beliefs that people exhibit must be learned, and so the most important task for psychology is to find out how people learn. Moreover, they suggested that the basic principles of learning, or acquisition of new behaviour, would be the same in any organism. Since there were clearly many ethical and practical advantages in carrying out laboratory research on animals rather than human beings, the behaviourists set about an ambitious programme of research into learning in animal subjects, mainly rats and pigeons.

Behavioural psychologists were eager to identify ways to apply their ideas to the explanation of psychological and emotional problems (Kazdin 1978). However, it was not until the years immediately after the Second World War, when there was a general expansion of psychiatric services in the USA, that the first attempts were made to turn behaviourism into a form of therapy. The earliest

applications of behavioural ideas in therapy drew explicitly upon Skinner's operant conditioning model of learning, which found practical expression in the behaviour modification programmes of Ayllon and Azrin (1968), and also used Pavlov's classical conditioning model as rationale for the systematic desensitisation technique devised by Wolpe (1958).

### Box 8.1: The cultural origins of CBT

When leading figures in the world of CBT write about how the approach was initially developed, they tend to place a strong emphasis on its origins in scientific research in behavioural psychology. However, it is also important to acknowledge that many of the techniques that are used in CBT can be traced back to methods of emotional self-control of 'mind training' that existed in Victorian nineteenth-century society, and even in earlier times, long before the advent of scientific psychology (Ablow 2008; Stearns and Stearns 1986; Thomson 2007). The current high levels of public acceptance of CBT as a method of therapy can be understood, in part, as a consequence of the degree to which CBT taps in to longstanding and deep-rooted ideas about conduct and relationships.

## Applying behavioural concepts and methods in therapy

Behaviour modification takes as its starting point the Skinnerian notion that in any situation, or in response to any stimulus, the person has available a repertoire of possible responses, and emits the behaviour that is reinforced or rewarded. This principle is known as *operant conditioning*. For example, on being asked a question by someone, there are many possible ways of responding. The person can answer the question, they can ignore the question, they can run away. Skinner (1953) argued that the response that is emitted is the one that has been most frequently reinforced in the past. So, in this case, most people will answer a question, because in the past this behaviour has resulted in reinforcements such as attention or praise from the questioner, or material reward. If, on the other hand, the person has been brought up in a family in which answering questions leads to physical abuse and running away leads to safety, their behaviour will reflect this previous reinforcement history. They will run off. Applied to individuals with behavioural problems, these ideas suggest that it is helpful to reward or reinforce desired or appropriate behaviour, and ignore inappropriate behaviour. If a behaviour or response is not rewarded it will, according to Skinner, undergo a process of extinction, and fade out of the behavioural repertoire of the person.

In one of the earliest examples of behaviourally informed therapy, Ayllon and Azrin (1965, 1968) applied these principles in psychiatric hospital wards, with severely disturbed patients, using a technique known as the 'token economy'. With these patients, specific target behaviours, such as using cutlery to eat a meal or talking politely to another person, were systematically rewarded by the ward staff, usually by giving them tokens that could be exchanged for rewards such as cigarettes or visits, or sometimes by directly rewarding them at the time with chocolate, cigarettes, or praise. At the beginning of the programme, in line with Skinner's research on reinforcement schedules, the patient would be rewarded for very simple behaviour, and the reward would be available for every performance of the target behaviour. As the programme progressed, the patient would only be rewarded for longer, more complex sequences of behaviour, and would be rewarded on a more intermittent basis. The aim eventually was to maintain the desired behaviour through normal, everyday social reinforcement.

The effectiveness of behaviour modification and token economy programmes is highly dependent on the existence of a controlled social environment, in which the behaviour of the learner can

be consistently reinforced in the intended direction. As a result, most behaviour modification has been carried out within ‘total institutions’, such as psychiatric and mental handicap hospitals, prisons, and secure units. The technique can also be applied, however, in more ordinary settings, such as schools and families, if key participants – teachers and parents – are taught how to apply the technique. It is important to recognise that punishment is not a necessary component of a behaviour modification regime. Skinner was explicit in stating that punishment would only temporarily suppress undesirable behaviour, and that in the long term behaviour change relies on the acquisition of new behaviour, which goes hand-in-hand with the extinction of the previous, inappropriate behaviour.

It is clear that behaviour modification does not sit easily within a typical counselling or psychotherapy relationship, which would normally seek to establish a supportive one-to-one setting in which the client can talk about their problems. Nevertheless, the principles of behaviourism and behaviour modification remain highly influential within contemporary CBT theory and practice, in the following ways:

*Collaborative empiricism.* A CBT therapist will explain behavioural ideas to the client and work with them to apply these ideas to bring about change in their own life. The client and therapist are then in a position to work together to observe patterns of behaviour, and then design new behavioural responses, which the client then tries out in the real world.

*Contextualism.* The concept of contextualism refers to the underlying philosophical position that underpins behavioural psychology (Hayes et al. 2012). There are two main threads to this way of thinking. First, to understand or explain any type of human action, it is necessary to take account of the context or environment within which it takes place. Second, the purpose of analysing human action is not to arrive at abstract theories, but rather to find ways to make the world a better place (pragmatism). These assumptions continue to guide and inform all versions of CBT.

*Functional analysis.* A key implication of Skinnerian behaviourism is that it is essential to pay attention to the consequences of behaviour (i.e. its function). A simple example of what is known as *functional analysis* (Cullen 1988; Sturmey 2007) of problem behaviour might involve a client who wishes to stop smoking. A behaviourally oriented therapist would begin by carrying out a detailed assessment of where and when the person smokes (the stimulus), what he does when he smokes (the behaviour), and the rewards or pleasures he experiences from smoking (the consequences). This assessment will typically identify much detailed information about the complex pattern of behaviours that constitutes ‘smoking’ for the client, including, for example, the fact that he always has lunch with a group of heavy smokers, that he offers round his cigarettes, and that smoking helps him to feel relaxed. This client might work with the counsellor to intervene in this pattern of smoking behaviour by choosing to sit with other, non-smoking colleagues after lunch, never carrying more than two cigarettes so he cannot offer them to others, and carrying out an ‘experiment’ where he smokes one cigarette after the other in a small room with other members of a smoking cessation clinic, until he reaches the point of being physically sick, thus learning to associate smoking with a new consequence: sickness rather than relaxation.

*Attention to causal sequences.* A key principle in behavioural psychology is that it should always be possible to identify and observe causal sequences, within the actual environment or context in which the person lives, that reinforce and maintain their patterns of problem behaviour. However, in human interaction, causality is rarely simple. In the example of the heavy smoker above, it might be possible to argue that his smoking is reinforced in several ways (i.e. there are multiple causal factors): (1) reduces anxiety; (2) leads to social contact and acceptance; (3) supports a self-image of being ‘macho’. There are probably also complex sequences of reciprocal causality: by offering cigarettes to his colleagues, the smoker reinforces their behaviour, which in turn reinforces (causes)

his own actions. For a behavioural therapist, the task of facilitating change involves dismantling existing causal sequences and replacing them with new ones. This involves developing a sensitivity to the complexity and nuances of different forms of causality (Haynes et al. 2012).

## Systematic desensitisation and exposure

In addition to ways of thinking such as collaborative empiricism and contextualism, behavioural psychology was responsible for two therapeutic techniques that have remained crucial parts of the CBT therapist's repertoire: systematic desensitisation and exposure.

The behavioural technique of systematic desensitisation was pioneered by Wolpe (1958). This approach relies on Pavlov's classical conditioning model of learning. Pavlov had demonstrated, in a series of experiments with dogs, that the behaviour of an animal or organism includes many reflex responses. These are unlearned, automatic reactions to particular situations or stimuli (which he called 'unconditioned stimuli'). In his own research he looked at the salivation response. Dogs will automatically salivate when presented with food. Pavlov discovered, however, that if some other stimulus is presented at the same time as the 'unconditioned' stimulus, the new stimulus comes to act as a 'signal' for the original stimulus, and may eventually evoke the same reflex response even when the original, unconditioned stimulus is not present. So Pavlov rang a bell just as food was brought in to his dogs, and after a time they would salivate to the sound of the bell even when there was no food around. Furthermore, they would begin to salivate to the sound of other bells (generalisation) and would gradually salivate less if they heard the bell on a number of occasions in the absence of any association with food.

Wolpe saw a parallel between classical conditioning and the acquisition of anxiety or fear responses in human beings. For a vivid example, imagine a person who has been in a car crash. Like one of Pavlov's dogs, the crash victim can only passively respond to a situation. Similarly, they experience an automatic reflex response to the stimulus or situation, in this case a reflex response of fear. Finally, the fear response may generalise to other stimuli associated with the crash: for instance, travelling in a car or even going out of doors. The crash victim who has become anxious or phobic about travelling, therefore, can be understood as suffering from a conditioned emotional response. The solution is, again following Pavlov, to re-expose the person to the 'conditioned' stimuli in the absence of the original fear-inducing elements. This is achieved through a process of systematic desensitisation. First of all, the client learns how to relax. The therapist either carries out relaxation exercises during therapy sessions, or gives the client relaxation instructions and tapes to practise relaxation at home. Once the client has mastered relaxation, the client and therapist work together to identify a hierarchy of fear-eliciting stimuli or situations, ranging from highly fearful (for example, going for a trip in a car past the accident spot) to minimally fearful (for example, looking at pictures of a car in a magazine). Beginning with the least fear-inducing, the client is exposed to each stimulus in turn, all the while practising their relaxation skills. This procedure may take some time, and in many cases the counsellor will accompany the client into and through fear-inducing situations, such as taking a car journey together. By the end of the procedure, the relaxation response rather than the fear response should be elicited by all the stimuli included in the hierarchy.

Although systematic desensitisation takes its rationale from classical conditioning, most behavioural theorists would argue that a full account of the development of maladaptive fears and phobias requires the use of ideas from operant, or Skinnerian, as well as classical conditioning. They would point out that although the initial conditioned fear response may have been originally acquired through classical conditioning, in many cases it would have been extinguished in the natural course of events as the client allowed themselves to re-experience cars, travel, and the outside world. What may happen is that the person actively avoids these situations, because they bring about feelings of anxiety. As a result, the person is being reinforced for avoidance behaviour – they are rewarded or reinforced by feeling more relaxed in the home rather than outside, or walking rather than going in a car. This 'two-factor' model of neurosis views the anxiety of the client as a conditioned emotional

response that acts as an avoidance drive. Through systematic desensitisation, the therapist can help the client to overcome their avoidance.

Over the years, these ideas have evolved in many different directions. For example, contemporary behaviour therapists might use mindfulness or soothing imagery, rather than (or in addition to) relaxation skills based on breathing and muscle relaxation. Nevertheless, underneath all of this, the key change mechanism is the process described more than a century ago by Pavlov: when a person has acquired a fear/anxiety response to something that is essentially harmless, such as travelling in a car, or being outside in the street, the fear will dissipate if the person is re-exposed to a fear-eliciting situation/context that they have been avoiding.

## The limitations of a purely behavioural perspective

The initial ‘behavioural’ stage in the development of CBT demonstrated that principles of behaviour change, derived from conditioning theories of learning, could be used to generate useful therapeutic techniques, and that methods of scientific research were of value in monitoring change in therapy clients. However, it became apparent that, in practice, behavioural techniques draw heavily upon the capacity of clients to make sense of things, to process information cognitively, and that a more cognitive theory was needed in order to understand what was going on. The social learning theory approach of Bandura (1971, 1977) demonstrated that learning could occur through observation and imitation, as well as through processes of operant and classical conditioning, and made an important contribution to the development of a more cognitively oriented form of therapy. This interest in cognitive aspects of therapy coincided with the emergence of the cognitive therapies, such as rational emotive behaviour therapy (Dryden 2015; Ellis 1962) and Beck’s (1976) cognitive therapy. These influences came together, during the 1970s and 1980s, to form what became known as cognitive behaviour therapy or cognitive–behavioural therapy.

## The emergence of cognitive approaches to therapy

Both Albert Ellis, the founder of rational emotive behaviour therapy, and Aaron Beck, the founder of cognitive therapy, began their therapeutic careers as psychoanalysts. Both became dissatisfied with psychoanalytic methods, and found themselves becoming more aware of the importance of the ways in which their clients thought about themselves.

The story of his conversion to a cognitive therapeutic perspective is recounted by Beck (1976) in his book *Cognitive Therapy and the Emotional Disorders*. He notes that he had been practising psychoanalysis and psychoanalytic psychotherapy for many years and had a patient who had been engaging in free association, and had become angry, openly criticising Beck. When asked what he was feeling, the patient replied that he felt very guilty. The patient then went on to explain that while he had been expressing his criticism of Beck, he had also had continual thoughts of a self-critical nature, including statements such as: ‘I’m wrong to criticize him . . . I’m bad . . . He won’t like me . . . I have no excuse for being so mean’ (Beck 1976: 30–31). Beck concluded that ‘the patient felt guilty because he had been criticising himself for his expressions of anger to me’ (Beck 1976: 31), and realised that it was not the guilt that was the problem, so much as the way the client *thought* about being guilty (‘I’m bad and mean for feeling like this’).

Beck (1976) described these self-critical cognitions as ‘automatic thoughts’, and began to see them as one of the keys to successful therapy. The emotional and behavioural difficulties that people experience in their lives are not caused directly by events but by the way they interpret and make sense of these events. When clients can be helped to pay attention to the ‘internal dialogue’, the stream of automatic thoughts that accompany and guide their actions, they can make choices about the appropriateness of these self-statements, and if necessary introduce new thoughts and ideas, which lead to a happier or more satisfied life. From the beginning, Beck highlighted commonalities



between cognitive and behavioural approaches to therapy: both employ a structured, problem-solving, or symptom-reduction approach, with a highly active therapist style, and both stress the 'here-and-now' rather than trying to reconstruct the client's childhood and early family relationships (Beck 1976).

A further element in Beck's (1976) model is the idea of *cognitive distortion*: the experience of threat results in a loss of ability to process information effectively. For example, the person may interpret events in ways that are highly selective, egocentric, and rigid (Beck and Weishaar 1989). Different kinds of cognitive distortion can be observed. *Over-generalisation* involves drawing general or all-encompassing conclusions from very limited evidence. For example, if a person fails their driving test at the first attempt they may over-generalise by concluding that it is not worth bothering to take it again because it is obvious that they will never pass. Another example of cognitive distortion is *dichotomous thinking*, which refers to the tendency to see situations in terms of polar opposites. A common example of dichotomous thinking is to see oneself as 'the best' at some activity, and then to feel a complete failure if presented with any evidence of less than total competence. Another example is to see other people as either completely good or completely bad. A third type of cognitive distortion is *personalisation*, which occurs when a person has a tendency to imagine that events are always attributable to their actions (usually to their shortcomings), even when no logical connection need be made. For example, in couple relationships, it is not unusual to find that one of the partners believes that the mood of the other partner is always caused by their conduct, despite ample proof that, for instance, the irritation of the partner is caused by work pressures or other such external sources.

### Box 8.2: The roots of rational emotive behaviour therapy in the early life experience of Albert Ellis

Albert Ellis was the founder of rational emotive behaviour therapy, one of the cornerstones of contemporary CBT practice. Ellis was born in Pittsburgh in 1913, the eldest of three children in a Jewish family, and grew up in New York. His father was frequently absent, and his mother was neglectful, and physically and emotionally unavailable to her children. His parents divorced during his childhood. Ellis was sent to school at the age of four, and was expected to cross busy roads without adult assistance in order to get there. He was seriously ill for much of his childhood, and was hospitalised for long periods with infrequent parental visits (Magai and Haviland-Jones 2002; Weiner 1988). Ellis has described how he responded to this neglect by reframing it as an opportunity to develop autonomy and independence, and claims that at the age of four he began to formulate a number of rules that were to guide him for the remainder of his life, such as 'hassles are never terrible unless you make them so', 'making a fuss about problems makes them worse', and 'use your head in reactions as well as your heart'. When he left school, he worked in business for ten years before putting himself through graduate school in clinical psychology. Initially trained in psychoanalysis, he quickly found himself reverting in his work with patients to his own rules for rational living, and by the early 1950s had developed his own approach.

Albert Ellis evolved an active therapeutic style characterised by high levels of challenge and confrontation designed to enable the client to examine their 'irrational beliefs'. Ellis (1962) argued that emotional problems are caused by 'crooked thinking' arising from viewing life in terms of 'shoulds' and 'musts'. When a person experiences a relationship, for example, in an absolutistic, exaggerated manner, they may be acting upon an internalised, irrational belief, such as 'I *must* have love or

approval from all the significant people in my life’. For Ellis, this is an irrational belief because it is exaggerated and overstated. A rational belief system might include statements such as ‘I enjoy being loved by others’ or ‘I feel most secure when the majority of the people in my life care about me’. The irrational belief leads to *catastrophising* that fuels feelings of anxiety or depression, if anything goes even slightly wrong in a relationship. The more rational belief statements allow the person to cope with relationship difficulties in a more constructive and balanced fashion.

The set of ‘irrational beliefs’, as identified by Ellis, provide the counsellor with a starting point for exploring the cognitive content of the client:

- I *must* do well at all times.
- I am a bad or worthless person when I act in a weak or stupid manner. I *must* be approved of or accepted by people I find important.
- I am a *bad, unlovable* person if I get rejected.
- People *must* treat me fairly and give me what I need.
- People who act immorally are undeserving, rotten people. People *must* live up to my expectations or it is terrible.
- My life *must* have few major hassles or troubles. I *can’t stand* really bad things or difficult people. It is awful or horrible when important things don’t turn out the way I want them to.
- I *can’t* stand it when life is really unfair.
- I *need* to be loved by someone who matters to me a lot.
- I *need* immediate gratification and always feel awful when I don’t get it.

These belief statements reflect the operation of a number of distorted cognitive processes. For example, over-generalisation is present if the client believes they *need* to be loved *at all times*. Cognitive therapists would dispute the rationality of this statement, inviting the client perhaps to reframe it as ‘I enjoy the feeling of being loved and accepted by another person, and if this is not available to me I can sometimes feel unhappy’. Other cognitive distortions, such as dichotomous thinking (‘if people don’t love me they must hate me’), arbitrary inference (‘I failed that exam today so I must be totally stupid’), and personalisation (‘the gas man was late because they all hate me at that office’) are also evident in irrational beliefs.

The ideas that underpin the cognitive therapies of Beck and Ellis are familiar ones within the broader field of cognitive psychology. For example, it has been demonstrated in many studies of problem-solving that people frequently make a ‘rush to judgement’, or over-generalise on the basis of too little evidence, or stick rigidly to one interpretation of the facts to the point of avoiding or denying contradictory evidence. An important aspect of cognitive distortion concerns the role of *memory* (Williams 1996). For example, people who are anxious, or who have undergone difficult life experiences, often find it difficult to remember painful events in detail. Their memories are over-generalised, so they recall that ‘something happened’, but they are unable to fill in the detail. The phenomenon of *metacognition* (Meichenbaum 1977, 1985, 1986) refers to the ability of people to reflect on their own cognitive processes, to be aware of how they are going about thinking about something, or trying to solve a problem. A simple way to illustrate metacognition is to reflect on your experience of completing a jigsaw puzzle. You will find that you do not just ‘do’ a jigsaw in an automatic fashion (unless it is a very simple one) but that you will be aware of a set of strategies from which you can choose as needed, such as ‘finding the corners’, ‘finding the edges’, or ‘collecting the sky’. Clients’ awareness of, and ability to communicate, metacognitive strategies is an important element in effective cognitive–behavioural therapy (Wells 2011).

Over the past 20–30 years, cognitive therapy has remained a distinct approach that has built on the early work of Beck and Ellis in devising cognitive strategies for working with an increasing range of client groups. However, probably the most significant contribution of the cognitive therapy tradition has been the combination of cognitive and behavioural ideas and methods, within what

became to be known as cognitive behaviour therapy or cognitive–behavioural therapy. By the 1970s, it had become apparent to practitioners, theorists, and researchers within both the behavioural and cognitive traditions that there was a natural affinity between the two perspectives. Significant turning points were the publication of *Cognition and Behavior Modification* by Michael Mahoney in 1974 and *Cognitive–Behavior Modification: An Integrative Approach* by Donald Meichenbaum in 1977. The combination of a structured approach to behaviour change, alongside attention to irrational or dysfunctional thoughts as a critical focus for change, led to a hugely productive stage within the history of counselling and psychotherapy, which saw a wide range of new techniques being developed for an increasing array of client populations.

## The practice of cognitive–behavioural therapy

Dobson and Dozois (2001) highlight three theoretical principles that inform all CBT:

- 1 Cognitive activity affects behaviour.
- 2 Cognitive activity may be monitored and altered.
- 3 Desired behaviour change may be affected through cognitive change.

Behind these core ideas lies a philosophical commitment to the application of scientific methods. There is a strong emphasis in CBT on measurement, assessment, and experimentation. Training and practice are grounded in what has been called the ‘scientist-practitioner’ model (Barlow et al. 1984), also known as the ‘Boulder model’, since it emerged from a conference held at Boulder, Colorado, in 1949 to decide the future shape of training in clinical psychology in the USA. The basic assumption of the scientist-practitioner model is that therapists should be trained in methods of systematic research, and routinely collect quantitative data on the outcomes of their work with clients. This has resulted in high levels of research productivity from adherents of CBT, with the consequence that there is much more evidence in respect of the efficacy of CBT than there is in relation to other models of counselling and psychotherapy. Some of this research has employed ‘ $N = 1$ ’ single case studies (see Chapter 30), which have made it possible to rapidly evaluate innovative interventions, whereas other CBT research has involved large-scale controlled trials. At a time when healthcare systems around the world are increasingly seeking to implement evidence-based practice policies (i.e. only funding the delivery of interventions that are backed by valid research evidence), this has given CBT therapists a major competitive advantage in the therapy marketplace.

It is important to recognise that CBT represents a broad tradition, with some practitioners operating more at the ‘cognitive’ end of the CBT spectrum, and others at the ‘behavioural’ end. Further discussion of discrete ‘schools’ of CBT can be found in Dryden (2012b) and Dryden and Branch (2012).

Unlike the psychodynamic and person-centred approaches, for example, which place a great deal of emphasis on exploration and understanding, the cognitive–behavioural approach is less concerned with insight and more oriented towards client action to produce change. In cognitive–behavioural work, the problem behaviour that has been troubling the client is identified and then modified in a systematic, step-by-step manner. The attraction of CBT, for many clients, is that it is experienced as purposeful and makes sense – it is made clear to the client what is expected from them, and how their efforts will lead to desired outcomes. The main areas of focus within cognitive–behavioural work are:

- *The therapeutic relationship*: establishing rapport and creating a working alliance between counsellor and client; explaining the rationale for treatment.
- *Assessment*: identifying and quantifying the frequency, intensity, and appropriateness of problem behaviours and cognitions.

- *Case formulation*: arriving at an agreed conceptualisation of the origins and maintenance of current problems, and setting goals or targets for change that are specific and attainable.
- *Intervention*: application of cognitive and behavioural techniques.
- *Monitoring*: using ongoing assessment of target behaviours to evaluate the effectiveness of interventions.
- *Relapse prevention*: attention to termination and planned follow-up to reinforce generalisation of gains.

The following sections examine each of these areas of therapeutic activity in more detail.

## The therapeutic relationship: establishing rapport and creating a working alliance

The creation of a relationship of safety and trust is an essential first step in CBT, as in any form of therapy. A central theme in the cognitive–behavioural literature and training is the notion of client–counsellor *collaboration*: the aim is for the client and CBT counsellor to be able to work together on identifying problems and implementing interventions. In contrast to other forms of therapy, such as psychodynamic or person-centred therapy, which regard the therapeutic relationship as itself a vehicle for change, CBT practitioners tend to view the relationship as necessary for the delivery of CBT interventions, but not necessarily as a focus of therapeutic work. However, the absence of an explicit emphasis on the therapeutic relationship in CBT should not be taken to mean that, in practice, CBT counsellors and psychotherapists do not value the establishment of a relational bond with clients. In recent years, interest has grown within the CBT community in the characteristics of the therapeutic relationship in CBT (Gilbert and Leahy 2007; Vandenberghe et al. 2018). Cognitive–behavioural therapy training and research makes use of checklists (Barber et al. 2003) and competency frameworks (Roth and Pilling 2007) that highlight relationship factors. The concept of socialisation of the client to a CBT way of thinking, through explanation, discussion, and the provision of reading materials, a key strategy for building a collaborative relationship, has proved to be critically important in the early stages of therapy (Daniels and Wearden 2011; Mahoney-Davies et al. 2017; Roos and Wearden 2009), with evidence showing that eventual poor outcomes may be attributable to failure to establish sufficient shared understanding at the outset (Chew-Graham et al. 2011).

### Box 8.3: Overcoming fear of flying: what helps?

Fear of flying is a good example of the type of problem that can often be addressed effectively from a cognitive–behavioural approach. But when a client receives a cognitive–behavioural intervention to combat fear of flying, what is it exactly that helps? Does change occur because irrational beliefs about air travel have been altered? How important is the fact that the client has acquired a new repertoire of behaviours, for example, relaxation skills? And how significant is the relationship with the cognitive–behavioural therapist? Do people get better because they trust their therapist, or want to please them?

Borrill and Foreman (1996) explored these issues in interviews with clients who had successfully completed a brief cognitive–behavioural fear of flying programme. The intervention comprised an initial session where the origins of the fear for the individual client were explored, and they were taught about the nature of anxiety. The second session was an accompanied return flight on a normal scheduled service. When asked about their experience of therapy, these clients had

a lot to say about the process of mastering their fear and panic. They reported that therapy had helped them to be able to understand their emotional arousal, and to apply a cognitive-behavioural model of anxiety in a way that made a real difference to how they felt. They became able cognitively to re-label difficult emotions. They had become able to think rationally about their experience of flying. Actually facing up to fear, by undertaking a flight, was also a valuable source of confidence. These experiences are consistent with cognitive-behavioural theory. However, these clients also reported that their *relationship* with the therapist had been crucial to the success of their therapy. The therapist was perceived as trustworthy, open, and warm. Clients described the therapist as legitimising and normalising their fear: she accepted that they were terrified, in contrast to friends or family members who had dismissed their feelings. Also crucial was a sense of the therapist as being in control. This enabled them to feel confidence in her, and thus to feel enough confidence in themselves to use the behavioural techniques that they had been taught.

## Assessment: identifying and quantifying problem behaviours and cognitions

An early task for any cognitive-behavioural therapist is to assess the problem that the client is seeking to change. This process will usually elicit information in four key domains:

- 1 *Cognitions*: the words, phrases, or images that are in the mind of the client when they are experiencing a problematic situation.
- 2 *Emotions*: the different feeling states that occur around the manifestation of the problem.
- 3 *Behaviour*: what the person actually does.
- 4 *Physical*: physiological or bodily symptoms associated with the problem.

Cognitive-behavioural assessment needs to be based in client descriptions, or narratives, of specific events that have been experienced – generalised accounts of ‘what usually happens’ do not yield information that is sufficiently precise for cognitive-behavioural work. During the assessment phase, the therapist invites the client to talk about problematic events, and aims to use these descriptions to find out as much as possible about the *content* that is present within each of the four domains (i.e. precisely *what* is being thought and felt), the *intensity* of the client’s experience (e.g. how strong is an emotion, how much is a disturbing belief considered to be true), and the *sequencing* of elements, or their re-occurrence in repeating cycles of dysfunctional activity. Informed by the stimulus-response basis of early behavioural psychology, much of the power of CBT assessment lies in the capacity of the therapist and client, working together, to identify sequences of cognition, emotion, behaviour/action, and bodily states.

It is not always easy for a client to report on problem sequences in the kind of detail that is required by a cognitive-behavioural therapist. In some cases, a therapist may need to use additional assessment techniques to augment the basic interview material that has been collected. There exist a large number of questionnaires and rating scales that are used by CBT practitioners to assess not only global levels of distress (e.g. intensity of depression or anxiety) but also specific areas of problem functioning (e.g. intensity of panic, obsessive-compulsive thinking, dysfunctional eating patterns). Clients may also be invited to engage in self-observation or *self-monitoring* during the assessment phase, for instance through being provided with charts or worksheets to fill in at home that require them to describe their thoughts, emotions, actions, and symptoms during specific problem incidents. Further information about these assessment tools can be found in CBT texts, including those by Kennerley et al. (2016), Ledley et al. (2005), Simmons and Griffiths (2017), and Wills (2014).

## Case formulation: arriving at an agreed conceptualisation of the origins and maintenance of current problems

One of the critical steps in CBT practice involves creating a case formulation, and sharing this framework with the client. The case formulation comprises a kind of mini-theory of the individual client and their problems. Within the formulation, the particular circumstances of the client's life and problems are explained in terms of CBT theory and concepts – the formulation statement can therefore be viewed as an application of CBT theory. The collaborative stance of CBT is reinforced through a process in which the formulation is explained to the client, the response of the client is used to sharpen the formulation, and the client is provided with a written copy of the formulation that will serve as a guide for subsequent work. Within the CBT professional community, there exist a number of different ideas about what makes an effective formulation. One of the leading figures in contemporary CBT, Jacqueline Persons, advocates that a good formulation might include the following elements (Persons 1993; Persons and Davidson 2001; Persons and Tompkins 2007; Persons et al. 1991):

- problem list – itemising the client's difficulties in terms of cognitive, behavioural, and emotional components;
- hypothesised mechanisms – one or two psychological mechanisms underlying the client's difficulties;
- account/narrative of how the hypothesised mechanisms lead to the overt difficulties;
- current precipitants – events or situations that are activating the client's vulnerability at this time;
- origins of the underlying vulnerability;
- treatment plan;
- obstacles to treatment.

Dudley and Kuyken (2006) suggest that a cognitive–behavioural case formulation should be constructed around the 'five Ps':

- presenting issues;
- precipitating factors;
- perpetuating factors;
- predisposing factors;
- protecting factors (person's resilience, strengths, and safety activities).

Whatever format is used to structure the case formulation, it is clear that it needs to incorporate explanatory accounts of both the current problem (what it is and how it is maintained) and the underlying personality predispositions or vulnerability that has created the conditions for the problem to emerge. It is also valuable to use the formulation to highlight the factors that might impede therapeutic progress (obstacles), or will be likely to facilitate it (sources of support, personal strengths).

In so far as the construction of a formulation – and its discussion with the client – represents the application of CBT thinking to the specific conditions of the client's own life, the formulation also opens up a space within therapy where the client can begin to learn about CBT concepts. This is a significant aspect of cognitive–behavioural work – ultimately, the aim is for the client to become their own therapist, and to become able to deal with future occurrences of problem areas by initiating CBT strategies on their own.



## Intervention strategies: the application of cognitive and behavioural techniques

A cognitive–behavioural therapist has access to a range of intervention techniques to achieve the behavioural objectives agreed with the client, and specified in the case formulation.

*Socratic dialogue.* During the assessment phase of CBT, and then throughout the course of therapy, the counsellor is on the lookout for irrational beliefs, automatic thoughts, negative self-statements, dichotomous (all-or-nothing) thinking, and other forms of cognitive processing associated with the emotional and relational difficulties being experienced by the client. The client is recruited to this endeavour, and may be provided with worksheets and exercises designed to enable them to develop skill and awareness in monitoring their own cognitive activity in problem situations. Once key cognitive processes have been identified, a CBT therapist engages in the activity of Socratic questioning (or Socratic dialogue) in order to facilitate further exploration of this material. This method is ultimately derived from descriptions of the approach taken by the Greek philosopher, Socrates, who was highly effective in asking questions that enabled his students to explore the underlying assumptions, and logical contradictions, that were inherent in their way of making sense of the world (Overholser 2010). Socratic questioning has two aims: (1) to lead the client in the direction of making connections between their thoughts and the behavioural consequences of these thoughts; and (2) opening a creative, reflective space within which new possibilities (i.e. different ways of thinking about things) might be realised. Examples of Socratic questions are:

- How much do you believe what you say about yourself?
- What evidence is there to support this belief?
- What evidence is there that contradicts your conclusions?
- What is the worst thing that could happen?
- What would happen if you were to . . . ?
- What would you advise someone else to do in this situation?

Effective facilitation of Socratic dialogue requires genuine curiosity, allied to empathy and sensitivity: the questions that are asked need to reflect the ‘track’ of the client’s own exploration of the issue, and must avoid any sense that the therapist is patronising the client. In a valuable review of the literature on Socratic questioning/dialogue in therapy, Carey and Mullan (2004) concluded that there exist many contrasting ideas about this procedure, reflecting the different aims and therapeutic styles of leading CBT writers. This suggests that Socratic questioning is more of a clinical skill – or art – rather than necessarily being grounded in scientific research. In terms of the process of cognitive–behavioural therapy, the fruits of Socratic dialogue lead to therapeutic activities that seek to reinforce cognitive shifts that may have occurred. For instance, within a session in which Socratic techniques have been employed, the therapist may work with the client to practise new ways of thinking, such as reframing (e.g. perceiving internal emotional states as excitement rather than fear) or actively rehearsing the use of different self-statements in role-play scenarios with the counsellor. Beyond this, new cognitive shifts may be tested out in homework assignments. Westbrook et al. (2011) provide a useful discussion of problems that can arise when using Socratic questions.

*Behaviour experiments.* An important aspect of CBT practice is that, unlike most other therapies, it does not merely involve talking about difficulties – CBT can also encompass enacting sequences of behaviour. Bennett-Levy et al. (2004) describe this practice as ‘behavioural experiments’, and their book contains many examples of different types of experiments used with clients with different problems and at different stages in treatment. Some of these experiments are carried out in the counselling room. For example, a client who has issues around personal boundaries in relationships

may be invited to sit closer to the therapist, or further away. A client who experiences agoraphobic panic attacks may be encouraged to be in the therapy room with the door locked. Other experiments can take place in the wider world. For instance, a client who is afraid to travel on their own might experiment with different lengths of bus journey. In some circumstances, clients may engage in experiments on their own; in other cases, the therapist may accompany them. Behaviour experiments give clients opportunities to practise new skills and ways of coping, or can involve confronting (rather than avoiding) feared situations or stimuli. As with all aspects of CBT, the effective design, planning, and implementation of behaviour experiments requires the establishment of a strong collaborative relationship between client and therapist. In practice, behaviour experiments are similar to, and overlap with, other categories of CBT intervention that are described next: social skills training, exposure techniques, and homework assignments.

*Assertiveness or social skills training.* In the 1960s and 1970s, a group of social psychologists in the UK, led by Michael Argyle, began to develop some practical clinical applications of research into social interaction. Their approach became known as *social skills training* (Argyle and Kendon 1967; Trower et al. 1978). Similar developments in the USA are usually described as *assertiveness training*. The central idea in social skills training is that people can develop psychological problems because they are not very good at engaging in micro-level social interaction sequences, which require appropriate and well-timed use of eye contact, conversational turn-taking, self-disclosure, voice quality and volume, touch, gesture, and proxemics. For example, a person may have grown up in a family in which no one engaged in eye contact or personal disclosure. On leaving home to go to college, the person then has great trouble in making friends, which in turn may result in social anxiety and depression. For such an individual, a therapeutic focus solely on cognitive processes is unlikely to be helpful – what they need is to learn the ‘rules’ of everyday social interaction. Social skills training protocols provide useful guidelines on how to structure this kind of learning. For instance, it is essential that the person learns how to collect accurate feedback on their social performance. In recent years, social skills or assertiveness training has largely disappeared as a distinct form of therapy. However, the ideas and methods of the approach have been incorporated into the intervention repertoires of many CBT practitioners.

*Exposure techniques.* From a CBT perspective, many of the problems that people develop are a result of a tendency to *avoid* threatening situations. Whereas many other therapies encourage clients to try to understand the nature of their fear and avoidance, CBT encourages clients to face the fear directly. This general technique is known as *exposure*. The assumption is that when a person purposefully engages with fearful situations, in a context in which they feel supported by a therapist, they will either realise that their fears are illusory (‘nothing bad happens to me when I hold a spider in my hand’) or that they possess coping skills that are adequate to allow them to tolerate the situation (‘I feel terrified being on an aircraft, but I know that if I practise my breathing and relaxation techniques and positive self-talk then I will survive it’). Conditioning theory predicts that, if a person continues to be exposed to a situation or stimulus in the absence of frightening consequences, the fear that has become a conditioned response to that stimulus will gradually fade or extinguish. By contrast, continued avoidance only serves to maintain the fear. The aim is the eventual replacement of anxiety or fear responses by a learned relaxation response. (The technique of *systematic desensitisation*, in which clients learn relaxation skills that are then applied in fearful situations, is an example of this principle.) In most cases, it is not sensible to begin by exposing the client to whatever is the most terrifying situation they can imagine – usually, the counsellor takes the client through a graded hierarchy of fear-eliciting situations, that have been discussed and planned in advance.

*Imagery rescripting.* The technique of *imagery rescripting* can be used if a client is bothered by intrusive memories of traumatic past events. The client is invited to keep the distressing image in mind and tell the story of what happened. After reflecting on the event, the client is asked to

‘rescript’ the event by imagining what would need to have happened to have made the original event less distressing. Alternatively, the client may be invited to observe the event from the point of view of their ‘adult self’. Examples of how this process operates can be found in Wheatley and Hackman (2011) and Wild and Clark (2011).

*Homework.* Homework assignments in CBT involve the practice of new behaviours and cognitive strategies, engagement in behavioural experiments, and collection of self-monitoring data between therapy sessions. A typical homework assignment might invite a client suffering from social anxiety to initiate a conversation with at least one new person every day, and write in a worksheet about the type and intensity of feelings that were elicited by these actions. Homework activity in CBT is firmly based in basic principles of behavioural psychology: a new behaviour may be acquired in one situation (i.e. elicited by a specific set of stimuli), but will rapidly be extinguished if it does not generalise to (i.e. be reinforced in) a range of other situations. For example, a client with social anxiety may fairly quickly develop confidence and fluency in speaking to their therapist – but the big test is to be able to reproduce that capability in everyday life settings. The potential advantages of homework are that it expands the impact of counselling beyond the therapy hour, creates a structure for the active participation of the client, and provides the possibility of success experiences for the client. The disadvantages of homework are that the client may become confused about what they have agreed to do, or may not be able to fulfil the task and as a result may become disillusioned with therapy. In a review of research into the use of homework in CBT, Kazantzis et al. (2005) specified the following principles for successful use of homework assignments in therapy:

- A rationale for homework assignments should be provided in the first session of therapy.
- Homework should be relevant to the client’s goals and aligned with their existing coping strategies.
- The homework task should be specific rather than vague.
- The therapist should check that the client understands what is expected.
- Written instructions should be provided.
- The assignment should not be discussed if the client is highly distressed.
- The outcome of a homework task should be discussed at the following session.

In addition, Kazantzis et al. (2005) suggest that therapists should accept that homework non-completion is a common occurrence, and refrain from becoming irritated or demotivated if the client does not appear to engage effectively with homework tasks. A comprehensive model of homework implementation has been devised by Scheel et al. (2004). Kazantzis et al. (2005) provide a useful brief checklist that clients and therapists can use to evaluate the effectiveness of homework in therapy.

*Mindfulness.* Mindfulness meditation is a way of being in which the person learns to accept the flow of thoughts and feeling without reacting to them. Originally part of Buddhist spiritual practice, mindfulness is viewed within CBT as a cognitive skill, or mode of attention, in which the person learns to accept and be aware of their experiencing. Mindfulness has been defined as ‘bringing one’s attention to the present experience on a moment-by-moment basis’ (Marlatt and Kristeller 1999: 68), or as ‘paying attention in a particular way; on purpose, in the present moment, and non-judgementally’ (Kabat-Zinn 1994: 4). Mindfulness was first adapted for use in Western therapy by Jon Kabat-Zinn (1990) and then further developed by Mark Williams and others (Williams and Kabat-Zinn 2013; Williams and Penman 2011).

Mindfulness can be incorporated into a CBT model by viewing it as an alternative response that disrupts the client’s usual cycle. Typically, a client might activate irrational and catastrophising cognitions in response to situations, in a way that heightens negative emotions and avoidance and limits possibilities for constructive problem-solving. If the client can, instead, engage in mindfulness, they

are able to engage more productively with what is actually happening. States of mindfulness are also, for most people, intrinsically pleasurable and self-reinforcing. The development of competence in mindfulness facilitates curiosity about inner states, and makes it possible to avoid being locked into ‘automatic thoughts’ and emotions. Within a CBT treatment plan and case formulation, mindfulness serves the same kind of function as a cognitive restructuring Socratic dialogue or psycho-education intervention that aims to change dysfunctional thoughts. In relation to the process of therapy and the client–therapist alliance, an advantage of mindfulness is that it does not involve trying to persuade the client that their existing way of thinking is wrong. Mindfulness skills are typically taught in a structured manner, often in a group, and there are many excellent self-help materials that support clients in their learning. On the whole, clients enjoy learning and practising mindfulness, and find it meaningful and satisfying.

*Using vivid and memorable metaphors, analogies, and stories.* Cognitive behavioural therapy theory and research tends to use dry, technical language that may not be immediately meaningful for clients. Cognitive behavioural therapists have developed a wide range of creative ways of explaining their approach to clients, using stories, analogies, and images. Examples of these practices can be found in Blenkiron (2005), Friedberg and Wilt (2010), and Stott et al. (2010).

*Self-help learning materials.* Cognitive behavioural therapists often supply clients with information sheets and worksheets that enable them to learn how to apply CBT ideas and use CBT methods to make changes in their lives. There are also a wide range of CBT-oriented self-help books that can be ‘prescribed’ to clients, on such topics as social anxiety (Butler 1999), panic (Silove and Manicavasagar 1997), obsessive-compulsive disorder (Veale and Wilson 2005), low self-esteem (Fennell 1999), depression (Gilbert 2000; Greenberger and Padesky 1995), chronic fatigue (Burgess 2005), and general anxiety (Kennerley 1997). There are also CBT-based on-line packages that can be used in a similar fashion (for example, Grime 2004). A key objective in using self-help materials is to enable the client to ‘become their own therapist’ and to become actively involved in treatment. The wide availability of CBT self-help books in bookshops and public libraries also has the effect of creating public awareness of CBT, so that at least some clients are informed about what to expect before they even meet their therapist, and have positive expectations for benefit.

## Monitoring: ongoing assessment of target behaviours

Influenced by its origins in behavioural psychology, CBT makes considerable use of measurement techniques to assess the severity of problems and to monitor change. A technique that is often used within sessions is the Subjective Units of Distress Scale (SUDS), where clients are asked to rate their level of anxiety or panic on a scale of 0–100. The SUDS technology provides a convenient shorthand means for clients and counsellors to communicate around severity of emotional distress, and the magnitude of change that may have resulted from therapy interventions or life events.

There are also a large number of standardised measurement instruments and scaling strategies that have been developed for therapy in relation to specific disorders. For example, there is good evidence that CBT is a particularly effective way of working with obsessive-compulsive disorder (OCD) (Salkovskis 1985; Whittal and O’Neill 2003). Typically, somewhere within the ritualised sequence of actions that are characteristic of OCD there are some automatic thoughts, and beliefs about the validity of these thoughts, that serve to maintain an obsessional way of living. However, these cognitions may be ephemeral and hard to keep in focus – the use of scaling helps both client and therapist to keep a handle on what is happening. A case study published by Guay et al. (2005; see Box 8.4) illustrates the variety of scaling and monitoring techniques that can be drawn upon by CBT practitioners working with this type of problem. A key aspect of the development of competence as a CBT therapist involves building up a resource bank of measures that are relevant to the client group with whom one is working.

### Box 8.4: Quantification as a means of maintaining therapeutic focus in the case of a person experiencing obsessional rituals

A case report by Guay et al. (2005) demonstrates some of the ways that monitoring is integrated into CBT treatment. The client was a married man of 38 years who had been diagnosed with severe OCD, high levels of anxiety, suicidal thoughts, and sleep disturbance. He had suffered from obsessive-compulsive symptoms for 30 years.

As a child, his alcoholic father had abused him psychologically, physically, and sexually, as well as being violent towards his mother. During adolescence, he began to believe that he might become like his father – something that made him overwhelmingly anxious. As a means of coping, he began to perform obsessive rituals and superstitions, which gradually dominated all aspects of his life. In order to track the overall effectiveness of therapy with this client, a set of questionnaires measuring levels of anxiety, depression, and obsessional beliefs were administered on a regular basis. To track micro-changes in specific areas of obsessional behaviour, the client was asked to generate a list of rituals (for instance, read aloud road signs when driving, check that the front door was locked, check if the oven was turned off), and rate each one of them on a series of scales to assess his strength of conviction in respect of (a) how likely it was that the thought would arise, (b) the likelihood of feared consequences if the ritual was not performed, and (c) the usefulness of the ritual. He also made ratings of his capacity to resist each ritual, and kept a diary of the amount of time each day engaged in OCD rituals.

Therapy (seven sessions) was very effective. It emerged that all of his obsessive thoughts and rituals stemmed from a core schema that ‘I must keep things under control . . . to avoid becoming like my father’. The careful measurement of key dimensions of his obsessional cycles enabled the client and therapist to tackle different aspects of belief and behaviour one at a time, and monitor the extent of change. For example, one homework assignment concentrated on finding examples of the futility of his behaviour, and how it prevented him from living as he wished. Monitoring was also reassuring for the client, in reminding him of the progress he had made at times in therapy when he felt insecurity due to the loss of his obsessional coping mechanisms at a point where new, more adaptive coping mechanisms had still to be developed. Finally, the existence of a set of measures that depicted his level of dysfunction at the start of therapy made it possible for the client to be confident, at three-year follow-up, that real changes had been achieved and maintained.

### Relapse prevention: termination and planned follow-up

A set of ideas and techniques that have come to be widely used by cognitive-behavioural therapists is associated with the concept of *relapse prevention*. Although many clients who are helped, through therapy, to change their behaviour may initially make good progress, they may at some point encounter some kind of crisis, which triggers a resumption of the original problem behaviour. This pattern is particularly common in clients with addictions to food, alcohol, drugs, or smoking, but can be found in any behaviour-change scenario. It is therefore necessary in cognitive-behavioural work to prepare for such eventualities by providing the client with skills and strategies for dealing with relapse events. The standard approaches to relapse prevention involve the application of cognitive-behavioural techniques. For example, the ‘awful catastrophe’ of ‘relapse’ can be redefined as a ‘lapse’. The client can learn to identify the situations that are likely to evoke a lapse, and



acquire social skills in order to deal with them. Clients may be given written instructions on what action to take if there is a threat of a lapse, or a phone number to call (Antony et al. 2005).

## Research into the effectiveness of CBT

Cognitive–behavioural concepts and methods have made an enormous contribution to the field of counselling and psychotherapy. Evidence of the energy and creativity of researchers and practitioners in this area can be gained by inspection of the ever-increasing literature on the topic. Cognitive–behavioural approaches appeal to many therapists and clients because they are straightforward and practical, and emphasise action. The wide array of techniques provide therapists with a sense of competence and potency. The effectiveness of CBT for a wide range of conditions is amply confirmed in the research literature.

The widespread adoption of CBT as the therapy most likely to be offered within healthcare systems, such as the Improving Access to Psychological Therapies (IAPT) initiative at NHS England, is largely due to the substantial research evidence that has accumulated concerning the effectiveness of CBT for a variety of disorders. The volume and quality of this research evidence has led some adherents of CBT to claim that their approach is the single most effective therapy model currently available. For example, the introductory CBT textbook by Kennerley et al. (2016) reviews the evidence for the efficacy of different approaches to therapy for a list of problem categories, such as depression, panic, anxiety, and so on and concludes that CBT is the treatment of choice for all of these conditions.

Although there is substantial evidence for the effectiveness of CBT, it is important to retain a balanced perspective on this issue. For example, a systematic review by Cuijpers et al. (2011) found that there is little difference in effectiveness for depression across any of the established therapy approaches. Lynch et al. (2010) came to similar conclusions in a review of the efficacy of CBT for major psychiatric problems such as schizophrenia. In a study of several thousand clients receiving counselling in the NHS, Stiles et al. (2006) found no differences in outcome between clients who had received CBT, person-centred counselling, or psychodynamic counselling.

The evidence base for CBT also needs to be interpreted in light of the fact that many CBT studies have focused on the effectiveness of specific CBT protocols designed to treat highly specific disorders, such as panic or obsessive-compulsive rituals. By contrast, the majority of clients or patients seen in routine practice settings have multiple problems, in which panic attacks may be mixed in with relationship difficulties, low self-esteem, and other issues. On balance, it seems reasonable to conclude that CBT is often an effective form of therapy that is well received by clients. But is it more effective than other forms of therapy? For very specific behaviour problems such as panic and OCD – possibly so. For more complex conditions such as depression, relationship difficulties, and anxiety – probably not.

## Critical issues in CBT theory and practice

Although it is clearly a highly successful approach to therapy, it is possible to identify areas of tension within the current overall structure of CBT theory and practice (Loewenthal and House 2010). One of these areas of tension arises from a disparity between a reliance by some practitioners (and trainers) on treatment manuals that outline highly specified treatment protocols for specific disorders, and the complex lives and realities represented by individual clients. This tension is reflected in the difference between the number of therapy sessions offered in research studies (where clients are carefully selected in terms of strict inclusion and exclusion criteria) and the number of sessions offered by therapists in private practice settings, working with complex cases. Westen et al. (2004) found that the average number of sessions in research studies that looked at CBT for depression



was significantly higher than the average number of sessions conducted in private practice by CBT therapists working with depressed clients.

Most CBT is delivered within frameworks provided by psychiatric categories (e.g. CBT for depression, CBT for anxiety, etc.). A major advantage of operating within a psychiatric nosology is that it strengthens the link between therapy and mainstream healthcare. However, it can be argued that CBT is, in a fundamental sense, an approach that is not conceptually consistent with the use of psychiatric categories. This is because CBT interventions are ultimately always individualised, and based on a detailed analysis of patterns of cognition, behaviour, and emotion that are linked to specific situations in the context of individual lives – it is not clear what is added to CBT case formulation by including a psychiatric diagnosis (see, for example, the discussion of this issue in Persons and Tompkins 2007).

For the past 50 years, influenced by the success of Beck's treatment protocols outlining cognitive interventions targeted at specific disorders such as anxiety and depression, the bulk of research and practice development within the CBT community has focused on disorder-oriented interventions (e.g. distinct CBT packages for clients with anxiety, depression, eating disorders, marital problems, post-traumatic stress disorder, etc.). This approach has been highly successful in terms of generating a strong research base demonstrating the efficacy of CBT for these disorders. However, it has led to problems in the field of routine practice. Typically, clients seen by frontline therapists report multiple problems. Treatment protocols that have been developed in the context of carefully selected 'single disorder' clients are hard to apply with clients who have comorbid or multiple conditions, because it is difficult to know where to start, and which condition should take priority. More recently, some CBT researchers and practitioners have sought to address such dilemmas by developing a *transdiagnostic* approach (Barlow et al. 2004; Clark 2009; Egan et al. 2011; Mansell et al. 2009; McManus et al. 2011). A transdiagnostic perspective seeks to identify maladaptive cognitive and behavioural processes that are found in all – or most – disorders. The transdiagnostic processes that have been studied so far include self-focused attention, perfectionism, avoidance behaviour, thought suppression, rumination, and safety-seeking behaviours. For example, perfectionism may represent the key underlying factor in the problems experienced by a client who has received a psychiatric diagnosis of depression plus anxiety plus OCD. In practice, adopting a transdiagnostic approach allows the therapist to build a case formulation and treatment plan around the particular factors that are most significant for each individual client, and then make use of evidence-based interventions that have been developed and validated for each transdiagnostic theme.

In some settings, CBT has been associated with high rates of drop-out from treatment (Bados et al. 2007; Westbrook and Kirk 2005). One factor here is that some clients may be reluctant to take part in behavioural experiments and homework assignments that involve exposure to fear-inducing scenarios (Jacobson et al. 2016; Pittig et al. 2018). A strategy that has been devised for dealing with this kind of clinical scenario has been to provide therapists with 'toolkits' that include a range of exposure options for clients (Becker-Haimes et al. 2017).

## The third wave: the flourishing of CBT

Over the last 20 years, the success of CBT has created a professional and research environment that has been able to support a substantial ongoing strand of creativity and innovation. Globally, several groups of researchers and clinicians have devised new configurations of CBT principles and techniques, in the form of a growing range of CBT-based therapy approaches. These developments have been described as 'third-wave' (or third-generation) CBT that builds on the first wave of behavioural methods and the second wave of cognitively oriented interventions. They can also be characterised as representing a willingness to learn from other therapy traditions, and make use of practices that have their origins elsewhere than the CBT community. In addition, there are important aspects of these new approaches that are informed by basic scientific research into memory, cognition, and neuroscience. Each of the third-wave approaches introduced below are supported by training programmes, research, and client workbooks.

## Dialectical behaviour therapy

One of the most important accomplishments within the field of psychotherapy as a whole over the last 30 years has been the development by Marsha Linehan and her colleagues of dialectical behaviour therapy (DBT). A key reason for the impact of this form of cognitive–behavioural therapy is that it has been devised as a means of helping people diagnosed with borderline personality disorder, a condition that has proved extremely hard to treat (by any method). Individuals with ‘borderline’ characteristics tend to have difficulty in forming lasting relationships (including with therapists), are troubled by strong, fluctuating emotional states, exhibit many forms of self-harm, and are prone to suicide. The approach developed by Linehan (1993a, 1993b, 1994) has been to address the needs of these individuals by assembling a comprehensive treatment package, incorporating intensive individual therapy, skills training in groups, regular supportive telephone contact, an explicit treatment contract, and structured support for the therapists involved in delivering the programme. Borderline personality disorder is conceptualised by Linehan (1993a) as ultimately grounded in a biological sensitivity to strong emotional responses to threat, exacerbated by childhood experiences (such as emotional abuse) in which the emotional reality of the person has been systematically invalidated by others. The key therapeutic principles of dialectical behaviour therapy encompass validation/acceptance of the person’s emotional distress and troubled life, coupled with resolute and consistent emphasis on learning new life skills in such areas as self-regulation and self-control of emotion, and coping with relationships. In the expectation that the client will not find it easy to participate in therapy, a variety of methods are utilised to provide a secure environment: contracting, long-term treatment, multiple helpers, and telephone support. For Linehan (1993a, 1994), the concept of the *dialectic* lies at the heart of the approach; the aim is to maintain a dialectical tension between acceptance of the client’s suffering, versus demanding that the client change their behaviour in the present moment.

While the underlying basis of DBT clearly reflects a behavioural approach, the treatment programme devised by Linehan is sensitively designed to meet the needs of individuals who have been invalidated by others, have learned to invalidate themselves, and as a result exist in a state of ‘unrelenting crisis’. The degree of difficulty that DBT clients experience in mastering new life skills, and the extent to which they need to be able to draw on the existence of a supportive group and people they can trust, is vividly illustrated in a study by Barnicot et al. (2015). Dialectical behaviour therapy is costly for health providers to offer, and demands a high degree of commitment from participants. As a result, DBT is not a frontline service, but tends to be used when other forms of help have proved not to be successful.

## Acceptance and commitment therapy

Acceptance and commitment therapy (ACT – spoken as a single word, not as initials) is a cognitive–behavioural therapy that has been applied to many different problem areas (Batten 2011; Hayes et al. 1999, 2006), and is probably the single most influential and widely available form of third-wave CBT. A crucial aspect of ACT is its explicit grounding in the philosophical position of functional contextualism that underpinned first-wave behaviour therapy (Hayes et al. 2012). A central underlying assumption of ACT is that a person’s problems arise from the use of language that fails to acknowledge the contextual basis of meaning (i.e. the person behaves as though their statements are objectively true for all time, rather than merely being true in specific contexts), which results in cognitive inflexibility. Hayes et al (2006) have developed a range of strategies for enabling clients to develop enhanced cognitive flexibility. These include:

- *acceptance* of thoughts and feelings, rather than trying to void them or defend against them;
- *cognitive defusion*, or altering the undesirable functions of thoughts – for example, a person might learn calmly to reflect that ‘I am having the thought that I am no good’, rather than getting locked into a struggle to eradicate the ‘I am no good’ cognition;

- *being present* – learning to experience the world more directly;
- having an appreciation of the person's sense of self or identity as a flow, rather than as a 'thing' (*self as context*);
- action based on consciously chosen *values*;
- *committed action* – the development of effective patterns of behaviour, which reflect personal values.

These strategies can be summarised in terms of a simple formula: 'Accept, Choose, and Take Action'. Implicit in the model is the idea that it is helpful for clients to extend their awareness and repertoire of possible actions; concentrating solely on one problem or dysfunctional cognition merely increases the importance of that 'node' within the overall consciousness of the person, and as a result reduces cognitive flexibility. Hayes et al. (1999) openly acknowledge the extent to which their approach has been influenced by a range of perspectives – experiential, humanistic, and gestalt therapies, feminist psychology, social constructionism, and narrative psychology. Nevertheless, they are clear that they have integrated these ideas into a therapeutic framework that is firmly located within the cognitive-behavioural tradition.

## Motivational interviewing

Motivational interviewing is an approach to therapy that was developed by Stephen Rollnick and William R. Miller in the 1980s (Miller 1983; Miller and Rollnick 1991, 2002). Initially, motivational interviewing was used mainly in the area of addictions, in working with people with drug and alcohol problems around making a decision or commitment to change their behaviour, and in the field of life-style change for people with life-threatening health conditions. More recently, the approach has been applied to a wide range of issues (Arkowitz et al. 2015; Miller and Rollnick 2013; Westra et al. 2011).

William R. Miller was originally trained in client-centred therapy, and the theoretical basis of motivational interviewing draws heavily on Carl Rogers' ideas about the qualities of a facilitative relationship. Miller and Rollnick (2009) have described motivational interviewing as an 'evolution' of client-centred therapy. However, while a person-centred counsellor adopts a rigorously non-directive stance, in the sense of following the client's 'track' in respect of whatever topic the client wishes to explore, motivational interviewing takes a somewhat more directive approach, in explicitly seeking to help the client to clarify their goals, values, and life choices. Wagner (2013) argues that it is appropriate to view motivational interviewing as a way of helping the client to overcome their ambivalence and resistance about making necessary changes in their life – equivalently, as a precursor to the actual behaviour and cognitive change work that occurs in CBT proper.

Motivational interviewing relies on four basic principles:

- 1 *Empathy*: the therapist seeks to view the issue from the frame of reference of the client.
- 2 *Developing discrepancy*: the therapist explores with the client tensions between how the client wants their life to be (the ideal) and their current behaviour (the actual).
- 3 *Acceptance or 'rolling with resistance'*: the therapist does not try to pressure the client to make a decision, but instead accepts that a reluctance to change is natural, and invites exploration of this resistance.
- 4 *Client autonomy*: the therapist respects the client as someone who has the capacity to arrive at the right decision for themselves in the present circumstances.

When these principles are implemented, a therapeutic space is constructed in which the client feels that they are in a relationship in which it is possible to talk honestly about all aspects of a decision, and as a result to be able eventually to make a genuine commitment to a new course of action that is grounded in a comprehensive exploration of all possible aspects of the issue. Rollnick and Allison (2004: 104) characterise the essence of motivational interviewing as that of creating an atmosphere

of constructive conversation about behaviour change, in which the therapist uses empathic listening to understand the client's perspective.

There has been a substantial amount of research into the effectiveness of motivational interviewing, both as an intervention in itself and as an adjunct to other approaches (Westra and Arkowitz 2011). There have also been studies of the use of motivational interviewing techniques by doctors, nurses, and other health professionals. These studies have generated strong evidence that motivational interviewing is well received by clients, and that it is as effective as any other method in facilitating change in hard-to-treat client groups (Burke et al. 2003; Lundahl et al. 2010; Miller and Rose 2009). Research shows that the goal-oriented focus of practitioners of motivational interviewing means that the client engages in more 'change talk', which eventually translates into 'change behaviour' (Miller and Rose 2009).

Motivational interviewing represents a creative synthesis of ideas and techniques from CBT and person-centred therapy. Apart from Wagner (2013), motivational interviewing has generally not been included as a topic in handbooks or textbooks of humanistic and person-centred therapy. By contrast, many articles on motivational interviewing have been published in CBT journals, and the approach is described as a form of CBT by Hayes et al. (2011).

## Mindfulness-based cognitive therapy

Mindfulness-based cognitive therapy (MBCT) is a form of CBT that integrates mindfulness meditation with Beck's cognitive therapy (Segal et al. 2001; Williams et al. 2006, 2007). Mindfulness is a meditation technique, taken from Buddhist practices (described in more detail in an earlier section of this chapter). Some writers have recently used the term *mindfulness-informed* cognitive therapy to describe this approach: as well as MBCT, mindfulness has also been integrated into DBT (Linehan 1993a, 1993b) and ACT (Hayes et al. 1999), as well as being used as an adjunct to other forms of therapy (e.g. Weiss et al. 2005). The founders of MBCT – Zindel Segal, Mark Williams, and John Teasdale – have been leading figures in the development of cognitive/CBT approaches to depression and suicidal behaviour, arguing that although CBT techniques are effective in helping people to recover from an episode of depression, there remains a high chance of recurrence of depression in the future. This seems to be because, once someone has suffered depression, a further episode of depression can be triggered by a relatively minor degree of negative mood. The person then finds that they are 'back to square one', and starts to question their own well-being, which in turn exacerbates the depressive state they are in. A capacity to engage in mindfulness meditation, by contrast, has the effect of protecting the person against a susceptibility to depression, by enabling them to become more aware of what is happening, stay in the present moment rather than ruminating on negative past events, and accepting feelings and emotions rather than trying to suppress them. Research evidence has shown that MBCT is effective in reducing the risk of relapse in depression (Teasdale et al. 2000). The MBCT group has produced a self-help book and CD to help disseminate their methods more widely (Williams et al. 2007). Theoretically, mindfulness represents a significant shift in relation to the therapeutic goals of CBT. The founders of CBT, such as Beck, Ellis, Mahoney, and Meichenbaum, developed a range of techniques that aimed to help a client to *change* the content of their thoughts. By contrast, the emphasis in mindfulness is not on forcing change, but on promoting awareness and acceptance.

## Other third-wave approaches

*Functional analytic psychotherapy* (Kanter et al. 2010) is a form of CBT that is distinctive in focusing on enabling the client to develop more satisfying relationships in their everyday life and by doing this by using the client–therapist relationship as a 'laboratory' for identifying dysfunctional patterns of relating and trying out new ones. Functional analytic psychotherapy is discussed more fully in the following chapter, in the context of interpersonal approaches to therapy.

*Compassion-focused therapy* is a CBT approach developed by Paul Gilbert that is informed by theory and research from Eastern and Western traditions, neuroscience, and evolutionary psychology (Gilbert 2010a, 2010b; Kolts et al. 2016). A key area of focus is on experience and behaviour around shame, self-loathing, and self-criticism, which are regarded as key drivers for many mental and physical health problems. Compassion-focused therapy is grounded in a formulation that helps the client to identify and understand the ways that they undermine themselves through harsh self-criticism and lack of self-acceptance. Therapy then offers structured learning around compassion skills, such as soothing rhythmic breathing, body scanning, finding a safe place, and accessing compassionate words and memories, before moving towards developing a 'compassionate self' and expressing compassion towards others. The effectiveness of these techniques is supported by a substantial body of research (Leaviss and Uttley 2015).

*Behavioural activation therapy* is a CBT intervention for depression that can also be relevant for clients whose difficulties include elements of depression. The principles of behavioural activation therapy represent a return to the Skinnerian and functional analysis roots of CBT – depression is understood as comprising a set of dysfunctional behaviours that can be changed one step at a time (Addis and Martell 2004; Jacobson et al. 2001). In behavioural activation therapy, clients learn to identify trigger situations that elicit depressive thoughts and behaviour, and to replace these patterns with more productive alternative strategies. There is considerable evidence for the effectiveness of this approach (Ekers et al. 2014).

*Schema therapy*. Cognitive therapists have been active in cataloguing a wide variety of problematic cognitive contents, referred to by different writers as irrational beliefs (Ellis 1962), dysfunctional or automatic thoughts (Beck 1976), self-talk or internal dialogue (Meichenbaum 1986), or 'hot cognitions' (Zajonc 1980), that punctuate everyday activities, and introduce disruptive emotional responses that undermine effective behaviour. A central aim of much cognitive work is to replace beliefs that contribute to self-defeating behaviour with beliefs that are associated with self-acceptance and constructive problem-solving. It can be helpful to access a deeper layer of cognition that underpins and maintains irrational beliefs and automatic thoughts. This deeper structure can be understood as *cognitive schema* – deeply held general statements that reflect the assumptions that the person holds about the world. For lasting change to occur, or in more serious cases, it seems to be necessary to move beyond the stage of identifying and challenging irrational beliefs and automatic thoughts, and to deal with the schema within which they are embedded. In *schema therapy*, developed by Jeffery Young (Farrell et al. 2014; Rafaeli et al. 2010; Young et al. 2003), schema are defined as patterns of cognition, memory, behaviour, and emotion that arise when basic childhood needs are not met. An example of a maladaptive schema is *abandonment*: a fundamental assumption that other people will not provide ongoing support or protection because they are emotionally unstable, unpredictable, unreliable, will die imminently, or abandon the person as soon as they meet someone 'better'. Schema therapy provides a means of helping the client to make links between current dysfunctional thoughts, childhood experiences of dysfunctional relationships, and patterns of interpersonal difficulty in their lives. A range of techniques are used in therapy. In addition to standard CBT methods, clients are invited to keep diaries, and the here-and-now interaction between client and therapist is used as a source of learning. Schema therapy is mainly used with clients with longstanding and severe difficulties such as personality disorders, or with clients who have not benefitted from other therapies (Bamelis et al. 2014). Schema therapy comprises a significant point of contact between CBT and the psychoanalytic object relations approach to therapy.

*Metacognitive therapy* was developed by Adrian Wells. Although this approach has been widely applied to many problem areas, it has particular relevance to anxiety and depression (Normann et al. 2014; Wells 2011). The distinctive contribution of metacognitive therapy is that it draws



attention not to the immediate thoughts that a person might experience in relation to a difficult situation (e.g. ‘I am useless’), but to their thoughts about these thoughts (‘Here I go again, I will never get this right, I must make sure I don’t get into this situation again’). This ‘meta’ level of thinking becomes apparent when a client is invited to describe what is going through their mind during phases of rumination and worry, when they monitor their environment for potential threats, or when they try to make sense of coping strategies that have not worked for them. Rather than feeling bad about something that has happened and then moving on, engaging in extended processes of negative metacognition has the effect of prolonging distress. Therapy involves formulation, explanation of the model, behavioural experiments, attention training, and a version of mindfulness.

## Reflections on third-wave CBT

The third-wave CBT approaches described in the preceding paragraphs only represent the most widely used CBT variants that are currently practised – other examples can be found in Dryden (2012b) and in the broader CBT literature. Taken as a whole, these developments reflect an eagerness to expand the boundaries of CBT theory and practice. Some of these new-wave CBT therapies have looked beyond psychology, into the realm of philosophy and religion, to find a deeper rationale for practical interventions that offer clients opportunities for life-changing experiences. Other variants represent a more detailed working-through of the implications of established CBT concepts and methods (Hofmann et al. 2010). Many of these approaches have sought to shift the emphasis of cognitive–behavioural work somewhat away from a sole focus on patterns of behaviour and cognition in problem situations, and towards an appreciation and acceptance of here-and-now experiencing. At the same time, while demonstrating a willingness to learn from other therapy traditions, these approaches have retained the core CBT values of brief therapy, close attention to the context within which behaviour occurs, providing clients with structure and clear guidelines around what is expected of them, and a commitment to evaluate outcome and process using rigorous methods of research.

To some extent, the flourishing of CBT has been made possible by the existence of a massive international professional community that is connected to university centres that provide high-quality training and research. Compared with other therapy approaches currently available, CBT can draw on a much larger ‘R and D’ establishment. More new ideas are thus being generated, compared with other approaches, and there is a greater capacity to evaluate and ‘road test’ these innovations. However, it is essential to acknowledge that the flourishing of CBT is also due to the warmth and enthusiasm with which clients and therapists have embraced these new ways of working. Behaviour therapy and classical CBT could be experienced, to some extent, as an interaction with a parental, teacher-like figure who tried to teach you to think properly and behave better. For the client, somewhere in that process was a subtle message that they had been doing things wrong for most of their life. While drawing on the same basic ideas, the new wave of CBT therapies offer clients a much more creative and joyful experience, one that opens up possibilities for living a fuller and more meaningful life. Practices such as self-compassion and mindfulness can be extremely satisfying and meaningful for clients. Therapists enjoy being able to offer these good experiences to clients, and clients want more of them.

In the long run, it is not possible to predict whether it will be possible to sustain multiple versions of CBT. It may be that training programmes and practising therapists will evolve hybrid integrations of CBT theory and practice that draw on different CBT models for particular therapeutic purposes, or that some kind of CBT meta-theory (or mega-theory) will emerge that incorporates all of them into one coherent theoretical structure. There are already some indications that some CBT therapists are drawing from different variants of CBT in response to the needs of clients. In effect, these therapists are treating the approaches described in the present chapter not as stand-alone therapy models that need to be delivered as an entire package, but as bundles of ideas and interventions



that can be selectively deployed as required. At the present time, each of the CBT variants outlined here are driven by founding figures who provide strong, inspirational leadership that has the effect of maintaining their approach as a discrete entity. At the point when these individuals stand aside, points of convergence may become more relevant than points of difference.

## Conclusions

The cognitive-behavioural tradition represents an enormous resource for therapists and clients. The practical and pragmatic nature of this approach means that there exists a wealth of therapeutic techniques and strategies that can be applied to different problems. In addition, the cognitive-behavioural approach has always had a healthy respect for the value of research as a means of improving practice, and this has enabled practitioners to be critical and questioning in a constructive way, and to learn quickly from the discoveries of their colleagues. Finally, of all of the therapies currently available, CBT is an approach that is particularly well-suited to the social and political environment of our time. It does not promise to deliver personal meaning or cultural transformation, or to challenge the disconnectedness and alienation of contemporary life. What it does do, is to help people to get back on track, to make the best of the life that is available to them.

A key strength of CBT is its philosophical grounding in pragmatic contextualism, a standpoint that supports an attitude of 'if it works, let's try it'. This openness to innovation can be contrasted with the tendency in many therapy approaches for practitioners to restrict themselves to ways of working that are consistent with their pre-existing theoretical system. One of the consequences of the openness to innovation that prevails in the CBT world is that different groups of practitioners have had the freedom to evolve new ways of doing CBT. In the early years of psychoanalysis, those with new ideas, such as Jung, Adler, and Reich, had to split off and set up new schools of therapy. By contrast, the CBT professional community has been able to keep the innovators inside the big tent. This process has led, over the last decade, to a flourishing of CBT, in the form of new interventions and new ways of thinking.



### Topics for reflection and discussion

- 1 What are the strengths and weaknesses of CBT compared with other therapy approaches you have studied or experienced? Are there specific strengths or weaknesses of CBT in relation to working with certain types of client problem, or certain categories of client?
- 2 What are the advantages and disadvantages of the strongly scientific emphasis of the cognitive-behavioural approach?
- 3 What are the advantages and disadvantages of using treatment manuals or protocols designed for specific client groups or disorders?
- 4 Select one of the CBT-informed self-help books listed in this chapter, or available in your local library or bookshop. How effective do you think it would be to rely on this book as a source of therapeutic assistance?
- 5 How culture-bound is CBT? Is it an approach to therapy that would only work for people who hold a Western set of values and worldview? Or is it universally applicable? Based on your knowledge of different cultures, reflect on some of the ways in which CBT might either be consistent with the norms, beliefs, and values of that culture, or might be culturally alien?

## Suggested further reading

Further exploration of themes and issues discussed in this chapter can be found in Dryden and Branch (2012). The discussion of case formulation in Kuyken et al. (2009) represents valuable insight into how to ‘think CBT’ and how to communicate these ideas to clients. A good way to learn about how CBT works in practice is to read through a CBT-informed self-help book or client workbook, such as those of Butler (1999), Silove and Manicavasagar (1997), Veale and Wilson (2005), Greenberger and Padesky (1995), or Williams et al. (2007). There are many excellent CBT journals. *Cognitive and Behavioural Practice* offers a stimulating source of new ideas in CBT. Insights about how CBT is applied in action can be gained by reading the well-documented case examples in the journal *Clinical Case Studies*. Hayes et al. (2011) and Dryden (2012b) are valuable sources in relation to third-wave CBT approaches.

# Chapter

# 9

## Interpersonal therapies

<b>Introduction</b>	<b>142</b>
<b>The historical roots of interpersonal therapy</b>	<b>142</b>
<b>Interpersonal psychotherapy</b>	<b>143</b>
<b>Functional analytic psychotherapy</b>	<b>146</b>
<b>Conclusions</b>	<b>148</b>
<b>Topics for reflection and discussion</b>	<b>149</b>
<b>Suggested further reading</b>	<b>149</b>

### Introduction

The concept of ‘interpersonal’ refers to what happens between (inter) two persons. Although the interpersonal process or field takes account of what happens within the person, such as thoughts, memories, and emotions, as well as the family, cultural, and social context, it focuses specifically on the particular realm of joint action between two persons. Attention to interpersonal processes lies at the heart of any approach to therapy in which healing is facilitated through the meeting of two (or more) persons. The interpersonal dimension of therapy is acknowledged through the use of such concepts as relational, alliance, attachment, transaction, conditions of worth, and self-concept. However, in addition to the inclusion of relational and interpersonal ideas in most therapy theories, there also exists a distinct tradition of interpersonal therapy, which takes as its starting point the ways in which the client interacts with other people, makes sense of problems in interpersonal terms, and seeks to help the client to develop more satisfying, supportive, and constructive relationships with others.

The present chapter begins by exploring the origins and development of an interpersonal perspective on therapy, then offers introductions to two contrasting interpersonal approaches that use somewhat different methods to arrive at similar outcomes: interpersonal psychotherapy and functional analytic psychotherapy.

### The historical roots of interpersonal therapy

To appreciate the nature of contemporary interpersonal therapy, it is essential to understand its origins. Historically, counselling and psychotherapy have been informed by ideas from psychology

and have adopted a largely individual-focused way of helping people to deal with problems in living. However, at the same time, there has always existed a somewhat hidden, parallel set of ideas, which have tried to make sense of personal problems in terms of relational and interpersonal processes (Cushman 1995).

A key figure in the development of an interpersonal approach to therapy was the American psychiatrist and psychoanalyst Harry Stack Sullivan (1892–1949). Although Sullivan published relatively little, he was at the centre of a group of therapists who, in the 1940s, established the William Alanson White Institute and the journal *Psychiatry* as vehicles for promoting interpersonal ideas and methods (Kanter 2013; Perry 1982). This professional network pre-dated, and strongly influenced, subsequent developments in relationally informed psychodynamic therapy, such as attachment theory, the ideas of Erik Erikson and R.D. Laing, and the emergence of family therapy in the 1950s.

Alongside his contribution to therapy theory and practice, Sullivan also played an important political role as an early supporter of gay and lesbian rights. He was also involved in the US war effort, advising on psychiatric screening of recruits to the armed services. Sullivan's key insight, as a therapist, was to acknowledge the importance for the person of relationships outside the family, such as friendships with other people at school. He was then able to see how emotional difficulties reflected the limitations of the person's ability to interact effectively with others. A key concept was the notion of 'consensual validation' – people develop an understanding of key events in their lives by talking to other people who were involved and arriving at a shared version of events. This simple idea represented a radical challenge to conventional psychoanalytic practice based on analysis of personal memories, fantasies, and dreams.

## Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) is an approach to therapy that was originally developed by the American psychiatrist, psychotherapist, and researcher Gerald Klerman (1928–1992) and further articulated in collaboration with his wife Myrna Weissman. An important figure in the history of therapy research as a whole – he was director of the US national mental health agency from 1977 to 1980 – the model of therapy devised by Klerman represented a judicious combination of ideas from medicine, psychoanalysis, and the interpersonal legacy of Sullivan, brought together in a package that would be amenable to research and could be readily disseminated through brief training programmes (Rosner 2018).

The initial IPT model was devised in 1969 by Klerman and a group of colleagues who were working with depressed patients in a psychiatric clinic but were not satisfied with the effectiveness of the newly developed forms of antidepressant medication that were available at that time (Weissman 2006). Aware that Aaron Beck had started to develop a manualised form of cognitive therapy for depression, they decided to construct a more psychodynamically and interpersonally oriented alternative (Rosner 2018; Weissman 2006). While retaining a belief in depression as a biologically based brain disease, they were aware of Sullivan's view that depression (and other psychiatric conditions) were precipitated by specific interpersonal conflicts, and by research into life events that supported such a position. The underlying influences are clearly visible in the model of therapy that they created. For example, IPT begins by explaining to the client/patient that they have been diagnosed with a psychiatric condition, and that it is possible to cope better with the condition by addressing the ways in which it affects their relationships with others. This strategy eliminates any responsibility that the client might feel for their problems (they have a medical condition that is outside their control) while at the same time introducing an interpersonal perspective without undermining their culturally held belief in the power of medicine. These ideas help clients to engage positively in therapy. The focus of therapy is then very much on identifying and coming to terms with life events (such as loss and bereavement) that have had a negative effect on interpersonal relationships.

Interpersonal psychotherapy has a straightforward structure that lends itself to training and is consistent with the requirements associated with delivering therapy in health service contexts. It was primarily developed as a form of therapy for depression – a condition that is clearly associated with multiple interpersonal problems such as social isolation and avoidance. Linking IPT to a specific psychiatric condition made it easier to rapidly accumulate a large amount of evidence for its efficacy for that condition, thus enhancing its credibility for clients, service providers, and would-be trainees. However, over time it has proved to be relevant and helpful for clients with a wide range of problems, including anxiety, eating disorders, and post-traumatic stress disorder (Cuijpers et al. 2016).

Interpersonal psychotherapy is generally delivered in a 16-session package comprising three distinct phases: beginning, middle, and end (Weissman et al. 2007). The initial phase can last up to three sessions. The aim in this phase is to collect information that will enable the therapist to construct an interpersonal formulation of the client's problems, which they can then offer to the client as a psycho-educational intervention as well as forming the plan for the work together. This information-gathering includes taking a psychiatric history: the medical model origins of IPT means that the therapy is carried out in a way that intentionally dovetails and complements any psychiatric interventions or ideas that are relevant for the client. The most distinctive aspect of the opening phase of IPT is the 'interpersonal inventory', which comprises a detailed interview in which the therapist systematically invites the client to discuss each of their current and past significant interpersonal relationships. Through the interpersonal inventory, and psychiatric history-taking, the therapist seeks to identify the interpersonal issues and specific life events associated with the current depressive (or anxiety, eating disorder, etc.) episode and any previous episodes. During the initial phase, the therapist also initiates the use of standardised measures, such as the Beck Depression Inventory, that will be used through the course of therapy as a means of monitoring progress. A range of specific IPT interview schedules and client self-completion forms have been developed to assist in the information-gathering and formulation stage of therapy (Weissman et al. 2007).

An IPT case formulation aims to identify one (or at most two) core interpersonal domains as the primary focus of therapy:

- *Grief/complicated bereavement*: the client began to have difficulties following the death of someone close to them.
- *Role dispute*: the problem was triggered by an unsatisfying, conflictual relationship in which each person had different expectations.
- *Role transition*: the origins of the problem are based in difficulties around coping with changes in the pattern of the person's life, such as health, employment, living conditions, and so on.
- *Interpersonal deficits*: the person appears to have a history of difficult relationships, rather than a current difficulty with a readily identifiable onset.

The main phase of therapy consists of a sustained exploration of (usually) one of these issues. The final phase of therapy comprises an ending or termination in which the aim is to consolidate the learning and change that has occurred over the course of therapy and consider what to do if difficulties re-emerge in the future.

The techniques and interventions used in IPT are grounded in the establishment of a warm, supportive, and collaborative therapeutic relationship. Although IPT is influenced by psychodynamic ideas, the interpretation of transference is not a technique that is employed. Instead, any feelings that the client may have towards the therapist are dealt with as valuable feedback around progress in therapy, or as examples of interpersonal patterns that may be relevant to real-life situations.

Interpersonal psychotherapy offers the client a plausible, pragmatic rationale for their problems, and a framework through which life changes may be made. The client therefore becomes an active participant in change. An important change mechanism is the opportunity to talk about and reflect

on life events and interpersonal difficulties – the client begins to understand how and why these problems have happened and is then able to initiate their own strategies for change. The therapist facilitates and deepens the process of reflection by eliciting specific concrete details of what happened in the client's life, encourages the expression of emotions that had been suppressed, seeks clarification around any statements that are vague or hard to follow, and gently challenges the client when they appear to be avoiding important aspects of an interpersonal transaction. These skills help the client to construct a more comprehensive appreciation of interpersonal aspects of their life, and to revisit events that had never been explored previously.

In addition to the skills, an IPT therapist makes use of a range of interventions and therapeutic activities. Communication patterns between the client and significant others are closely examined. The aim here is to assist the client to achieve a more valid understanding of what the other person might intend or mean, and to express their own wishes and feelings in a more effective manner. Decision analysis focuses on exploring different courses of action around an interpersonal issue. Role-play involves client and therapist enacting, in the session, problematic scenarios from the client's life, and rehearsing more satisfactory ways of responding. This may include an imaginary conversation between the client and someone who is deceased. Although the primary aim of the therapist is to enable the client to generate their own solutions, the therapist is very much an active participant in the process, who is willing to make suggestions where appropriate.

In conclusion, IPT is a form of therapy that has been found to be acceptable to clients from many backgrounds and has been successfully adapted for implementation in non-Western contexts such as Kenya and Ethiopia. By focusing on actual changes that the client can make in their relationships with others, it functions as a means of engaging client agency and constructively channelling their motivation to change. Through offering a structure that allows the therapist to draw on pre-existing interpersonal skills and life experience, augmented by a range of practical tools and worksheets, and an international support network, it does not require lengthy training.



### Case study 9.1: The case of Barbara – IPT in action

Barbara, a married woman with two daughters, was 37 when she entered interpersonal psychotherapy to deal with long-term depression. Up until the birth of her second child, seven years previously, she had been the manager of a social services department. Her daughter had been born with a medical condition that required a period of hospitalisation followed by 24-hour care. Barbara had been unable to return to work following maternity leave because of the depression. She then became a carer for her daughter (which involved sleeping in her daughter's room every night) and advocate for her daughter's rights.

During the assessment and history phase of therapy, it emerged that Barbara had experienced episodes of depression at earlier points in her life and had a good relationship with her husband but longstanding difficulties in her relationship with her mother. Since the birth of her daughter, Barbara had received both medication and CBT, each of which had only been helpful to a limited extent. The process of engaging in an interpersonal inventory allowed Barbara to reflect on these aspects of her life and begin to make connections between them. It made perfect sense to her when her therapist offered a formulation based in the idea that she had an underlying biological predisposition to depression that had been exacerbated by the dramatic role transition that had occurred following the birth of her daughter, particularly the loss of a valued identity as a competent and effective manager. The course of therapy included sessions devoted to analysing the ways in which Barbara failed to communicate her own needs to others and trying out different strategies for achieving this. A particularly important piece of therapeutic work focused on



a specific recent interaction with her mother, leading to role-play of alternative ways of handling that relationship. Another significant event in therapy centred on Barbara's unwillingness to complete the routine depression-monitoring questionnaire, and a discussion of her experience of that episode (she imagined the therapist would be angry and was surprised when she was not) that crystallised important aspects of her new way of relating to people.

By the end of therapy, Barbara was able to let go of her previously idealised role as a manager. She was able to embrace her new identity as a mother of a disabled child, and to secure part-time work that allowed her to enjoy a network of work colleagues. She had become much more effective in communicating her needs to, and receiving support from, her husband and mother. Overall, therapy had enabled Barbara to complete an important role transition in her life, while at the same time gaining valuable interpersonal skills and an understanding of links between mood and relationships.

[A more complete account of this case, including explanation of the rationale for therapist choices at different stages in therapy, can be found in Ravitz and Maunder (2012).]

## Functional analytic psychotherapy

Functional analytic psychotherapy (FAP) is a unique behaviourally oriented form of interpersonal therapy, originally developed in the 1980s by Robert Kohlenberg and Mavis Tsai. Although it can be considered as an example of 'third-wave' CBT, it is firmly grounded in principles of Skinnerian operant conditioning and learning that stretch back to the early history of behavioural psychology (Kohlenberg and Tsai 1994).

Functional analytic psychotherapy is a model of therapy that is currently enjoying widespread attention and influence (Kanter et al. 2010; Kohlenberg and Tsai 1991; Tsai et al. 2009, 2012, 2014). The key idea in FAP is a focus on how the client exhibits behaviours in their relationship with the therapist, that are either examples of problem behaviours that are causing them difficulties in their everyday relationships, or more constructive new behaviours that represent positive learning and change. The aim is to use awareness of what is happening interpersonally between client and therapist, as a step in the direction of more constructive client–therapist relating that can be generalised to real-life relationships.

In FAP, significant in-session client interpersonal responses are called clinically relevant behaviours (CRBs). The task of the therapist is to respond to the client in ways that diminish the occurrence of problematic CRBs and encourage the performance of positive CRBs. In this respect, the therapy is directly analogous to Skinnerian animal experiments (operant conditioning), for example where a pigeon in a cage would be rewarded with food for certain behaviours, while other behaviours are ignored and as a result would gradually fade away. The 'rules' of FAP are:

- 1 Watch for CRBs.
- 2 Evoke CRBs.
- 3 Reinforce CRBs naturally.
- 4 Observe the potentially reinforcing effects of therapist behaviour in relation to client CRBs.
- 5 Provide functionally informed interpretations.
- 6 Implement generalisation strategies to support transfer of new behaviour to everyday situations.

In FAP, the client is enlisted as a partner in the change process, by being given an explanation of the rationale for the therapy (the FAP therapist's 'rap').

The client is also asked to complete take-home 'bridging worksheets' that invite them to reflect on the previous session, identify an agenda for the following session, and observe their own behaviour in the intervening period. Examples of 'bridging' questions are:

Was there anything in the session you were reluctant to say or ask for?

What issues came up for you in the session/with your therapist that are similar to your daily life problems?

What emotional risks did you take in the session/with your therapist and/or what progress did you make that can translate into your outside life?

What were the high and low points of your week? (to be completed just prior to next therapy session)

What items, issues, challenges, or positive changes do you want to put on the agenda for our next session?

These worksheets and questions are intended to encourage the client to reflect on their own participation in therapy, as well as providing feedback for the therapist.

A highly distinctive aspect of FAP is the level of demand that it places on the therapist, who needs not only to be aware of CRBs as they happen, but also to come up with immediate responses to the client that are consistent with the case formulation (i.e. targets around CRBs) as well as being experienced as authentic and honest. An example of how FAP works in practice might be a depressed client with a history of failed relationships. In exploring this issue with the therapist, it could emerge that the client's relationships were characterised by a pattern of pushing people away if they got too close. 'Pushing people away' would be identified as a target CRB to be changed. In respect of in-session behaviour that the therapist might be able directly to modify, they would be on the alert for instances when the client pushed them away. For example, at such a moment, the therapist might say, 'I expressed caring, and you pushed me away') and go on to inquire whether a similar process occurred in the client's marriage (Tsai et al. 2010). At other moments in therapy, the therapist might comment on instances where the client had stayed in connection, rather than pushing them away.

To carry off this kind of interaction in a manner that is plausible to the client, rather than coming across as false or as a professional façade, a FAP therapist needs to be able to draw on their own experience. This is because the aim is to reinforce more positively functional ways of being on the part of the client. A superficial response is unlikely to be reinforcing – what is required is what FAP theory describes as 'therapeutic love'. In addition, the more genuine the therapist is, the more likely that the client will exhibit key CRBs. By contrast, if the therapist is distant and polite, the client will behave in a more controlled manner. Therapist courage is therefore another central element of a FAP way of working.

In practice, therapist engagement with CRBs will often make use of strategic and deliberate use of self-disclosure (Vandenberghe et al. 2006). In a classic account of how therapist self-disclosure is deployed in FAP, Tsai et al. (2010) describe how, at the time of her (Mavis Tsai) mother's illness and then death, she took some time off, and sent an email to all of her clients telling them, in a highly personal way, what was happening and what it meant to her. On her return to work, she found that almost all of her clients reported that this communication had been helpful for them, and many of those who struggled with issues around closeness and expression of feelings were able to exhibit positive in-session actions in these areas (and be reinforced by Mavis Tsai for doing so).

An important aspect of the theory that underpins FAP practice is the ACL model of behaviour that contributes to interpersonal connection. *Awareness* (A) behaviours are centred on observing and paying attention to the needs and values of both participants in a relationship. *Courage* (C) behaviours are focused on being able to experience emotion in the presence of another person, asking for what you need, and sharing deep, vulnerable experiences with another person. Finally, *Love* (L) behaviours emphasise being responsive to the needs and emotions of the other person, through being able to be tuned in to that person, and accept their vulnerability. The expression of love enables a relationship to be a safe place for the other person. While these principles reflect a broadly

humanistic and existential perspective, they do so in a way that specifies what a person can actually do (and learn to do) to build effective and satisfying interpersonal connection (Leonard et al. 2014).

It is clear (and acknowledged by FAP authors) that the kind of therapeutic process that occurs during FAP is similar to the psychodynamic process of working with client transference. However, FAP does not define itself as a psychodynamic therapy, because FAP therapists work with this kind of process in a more transparent and pragmatic way, informed by a different underlying conceptual model.

In contrast to other variant CBT therapies, less research had been conducted into the process and outcomes of FAP (Busch et al. 2009; Landes et al. 2013; Lizarazo et al. 2015; Maitland and Gaynor 2016; Maitland et al. 2016). Instead, effort has been directed towards generating innovations in treatment that are consistent with FAP philosophy (Tsai et al. 2017) and publishing case examples that illustrate how the approach works in practice.



### Case study 9.2: The case of Tim – functional analytic psychotherapy in action

Tim was a 35-year-old single man who worked in information technology and received 30 sessions of FAP over a 12-month period. The therapy sessions were spread out to allow Tim time to practise new behaviour in everyday contexts. Tim had started a new job and entered therapy because he felt he was a failure. He engaged in obsessional rumination and self-criticism. He was struggling to meet the demands of his job, and had largely withdrawn from social relationships and from emotional intimacy with his girlfriend. Earlier in his life, he had experienced significant physical health difficulties that had undermined his performance at school. He was an only child, in a family in which emotional expressiveness was discouraged. He believed that he was a failure and that other people would reject him if they really knew what he was like.

An emergent theme in early sessions was a wish to be more in contact with his body, and to be able to be closer to other people. From a FAP perspective, clinically relevant behaviours exhibited in therapy sessions included watching the therapist to check if what he was saying was acceptable, laughing when feeling uncomfortable, avoiding eye contact at moments of potential connection, reassurance-seeking, and over-intellectualising. Alternative behaviours that were reinforced in therapy sessions and everyday situations included taking risks to gain emotional closeness, asserting personal needs, and being more self-compassionate. To support learning around these areas, Tim was invited to keep a FAP weekly emotional risk log. At the same time, the therapist used supervision to review her own sensitivity and responsiveness to Tim's clinically relevant behaviours (CRBs). Towards the later stages of therapy, Tim worked on tasks around 'letting his heart guide him' in relationships and 'living with uncertainty'. In the closing sessions, he completed a 'personal mission statement' in which he defined his personal passions and life goals, and how he would live up to these values in future. As a means of reinforcing the authenticity and connections that characterised their relationship, his therapist read him parts of her own mission statement. At the start of therapy, Tim had recorded high scores on a set of standardised symptom measures. At the end of therapy and at one-year follow-up, his scores on these measures were all in the 'healthy' range.

[A more detailed account of this case can be found in McClafferty (2012).]

## Conclusions

Interpersonal psychotherapy and functional analytic psychotherapy are well-established approaches to therapy that are supported by professional networks and associations, training programmes, and

research evidence. At a theoretical level, they share a common focus on interpersonal dimensions of problems in living, but approach the task of facilitating learning and change in radically different ways: IPT mainly works with what is happening outside the room, while FAP mainly works with what is happening in the room. Theoretically, the effectiveness of IPT and FAP raises important questions for established therapy approaches such as psychodynamic and humanistic, that are similarly interested in interpersonal themes but place these within the context of the inner cognitive-emotional functioning of the client. The clinical outcomes achieved in IPT and FAP suggest that foregrounding the interpersonal seems to be an effective therapeutic strategy in the absence of any particular attention to intrapersonal factors. Another similarity between IPT and FAP is that they represent sets of ideas and skills that can be readily integrated into other models of therapy. The major differences between the two psychotherapies lie in the area of core theoretical assumptions, which are about as different as they could be, and therapist style. Interpersonal psychotherapists adopt a way of being that offers the client a relationship that is in many ways close to what they might expect from a close and caring friend. By contrast, FAP therapists are more like performance artists who intentionally use their own presence to disrupt the client's taken-for-granted assumptions about how to connect with others.



### Topics for reflection and discussion

- 1 Identify one problem in living that has caused you to feel anxious or depressed, and which is now mainly resolved. To what extent is it possible, in retrospect, to make sense of that problem in interpersonal terms? To what extent, and in what ways, did the process of addressing that problem require learning new ways of communicating with others?
- 2 What is the theoretical and practical significance of the fact that both IPT and FAP acknowledge a debt to Freud's theory of transference, while being at pains to make it clear that they do not apply his ideas in their work with clients?
- 3 Other chapters of this book introduce a wide range of other therapy approaches. To what extent does the success of these approaches depend on their capacity to explore interpersonal concerns (and their limitations or failures an avoidance of such concerns)?
- 4 Social isolation and loneliness have been identified as major problems in contemporary society that are particularly acutely experienced by both younger and older people. In what ways can IPT and FAP be applied to such issues?

### Suggested further reading

Any of the main textbooks of IPT and FAP, cited in this chapter, provide well-written, accessible accounts that explain in detail how these approaches work in practice. In terms of developing a critical perspective on IPT and FAP, any of the recommended reading listed at the end of Chapter 3, which looks at the therapy relationship, and the ideas contained within the chapter itself, are highly relevant.

# Chapter 10

## Person-centred, humanistic, and experiential approaches

<b>Introduction</b>	<b>151</b>
<b>The philosophical and cultural underpinning of the humanistic therapies</b>	<b>151</b>
<b>The evolution of the person-centred approach</b>	<b>152</b>
<b>Theoretical framework of the person-centred approach</b>	<b>153</b>
The therapeutic relationship	155
Empathy	156
Congruence and presence	157
The therapeutic process	158
Experiential focusing	159
<b>Further developments in person-centred theory and practice</b>	<b>161</b>
Agency	162
Self-multiplicity	162
Relational depth	163
Mutuality	163
Strategies of disconnection	164
Difficult process	164
Post-traumatic growth	165
<b>Other humanistic therapies that build on the person-centred approach</b>	<b>165</b>
Expressive therapy	166
Pre-therapy and contact work	166
Emotion-focused therapy	166
Humanistic counselling	169
<b>Links between the person-centred approach and other therapy traditions</b>	<b>169</b>
<b>Conclusions</b>	<b>169</b>
<b>Topics for reflection and discussion</b>	<b>170</b>
<b>Suggested further reading</b>	<b>170</b>

## Introduction

The approach to therapy developed by Carl Rogers and his colleagues, called at various times ‘non-directive’, ‘client-centred’, ‘person-centred’, or ‘Rogerian’, has not only been one of the most widely adopted models of counselling and psychotherapy over the past 70 years, but has also supplied ideas and methods that have been integrated into many other approaches. This chapter provides an overview of the person-centred approach to therapy, in the context of the cultural and philosophical sources that shaped its origins, an account of how the approach has evolved over time, its key principles, and emergent forms of practice. It also explores the distinctive contribution of other humanistic and experiential approaches to therapy that have been strongly influenced by person-centred ideas and values.

## The philosophical and cultural underpinning of the humanistic therapies

The emergence of client-centred therapy in the 1950s was part of a broader movement in American psychology to create a ‘humanistic’ alternative to the two theories which at that time dominated the field: psychoanalysis and behaviourism. This movement became known as the ‘third force’ (in contrast to the other main forces represented by the ideas of Freud and Skinner). Apart from Carl Rogers, the central figures in early humanistic psychology included Abraham Maslow, Charlotte Buhler, and Sidney Jourard. These writers shared a vision of a psychology that would have a place for the human capacity for creativity, growth, and choice, and were influenced by the European tradition of existential and phenomenological philosophy, as well as by Eastern religions such as Buddhism. The image of the person in humanistic psychology is of a self striving to find meaning and fulfilment in the world. Bugental (1964) formulated six ‘basic postulates’ for humanistic psychology:

- 1 Human beings, as human, supersede the sum of their parts. They cannot be reduced to components.
- 2 Human beings have their existence in a uniquely human context, as well as in a cosmic ecology.
- 3 Human beings are aware and aware of being aware (i.e. they are conscious).
- 4 Human consciousness always includes an awareness of oneself in the context of other people.
- 5 Human beings have some choice and, with that, responsibility.
- 6 Human beings are intentional, aim at goals, are aware that they cause future events, and seek meaning, value, and creativity.

Humanistic psychology has always consisted of a broad set of theories and models connected by shared values and philosophical assumptions, rather than constituting a single, coherent, theoretical formulation (Cain 2002; McLeod 2002; Rice and Greenberg 1992). Within counselling and psychotherapy, the most widely used humanistic approaches are person-centred, gestalt, and emotion-focused, although psychosynthesis, transactional analysis, and other models also contain strong humanistic elements. The term ‘experiential therapy’ is sometimes used to describe these approaches, because of their shared acknowledgement of the primacy of working with the here-and-now experiencing of the client and therapist. Following a period in which the humanistic tradition appeared to be waning as a source of influence and inspiration in counselling and psychotherapy, there are signs of a revival in this orientation (Cain et al. 2016; Schneider and Längle 2012; Schneider et al. 2014).

The person-centred approach, along with other humanistic therapies, places a strong emphasis on working with the actual momentary lived experiencing of the person. Because of this, these



approaches espouse a *phenomenological* approach to knowledge. Phenomenology is a method of philosophical inquiry evolved by Husserl and other thinkers (see Moran 2000; Moran and Mooney 2002), which is widely employed in existential philosophy, and which takes the view that valid knowledge and understanding can be gained by exploring and describing the way things are experienced by people (rather than trying to construct knowledge through abstract theorising). The aim of phenomenology is to depict, grasp, and understand the nature and quality of personal experience. Phenomenological inquiry involves ‘bracketing off’ the assumptions one holds about the phenomenon being investigated, and striving to describe it in as comprehensive and sensitive a manner as possible. The act of ‘bracketing off’ or ‘suspending’ assumptions is carried out to ensure that, as far as possible, the phenomenological researcher (or therapist) does not impose their theoretical assumptions about experience on to the phenomena (events, process, experiences) that are the object of inquiry.

## The evolution of the person-centred approach

The birth of the person-centred approach is usually attributed to a talk given by Carl Rogers in 1940 on ‘new concepts in psychotherapy’ to an audience at the University of Minnesota, subsequently published as a chapter in *Counseling and Psychotherapy* (Rogers 1942). Rogers suggested that the therapist could be of most help to clients by using a ‘non-directive’ approach that allowed them to find their own solutions to their problems. In 1945, Rogers was invited to join the University of Chicago, as Professor of Psychology and Head of the Counseling Center. Over the following 20 years, a whole new generation of American counsellors was trained at Chicago, or by colleagues of Rogers at other colleges. Rogers was also successful during this period in attracting substantial funding to enable a continuing programme of research, which resulted in a shift away from the concept of ‘non-directiveness’ in the direction of what became known as a ‘client-centred’ way of working that involved consideration of the process that occurred in the client, particularly in relation to changes in the self-concept of the client (Rogers 1951; Rogers and Dymond 1954).

A further phase in the development of client-centred counselling and psychotherapy focused on developing a research-informed model of the therapeutic relationship. Rogers’ 1957 paper on the ‘necessary and sufficient’ conditions of empathy, congruence, and acceptance, later to become known as the ‘core conditions’ model, was an important landmark in this phase, as was his formulation of a ‘process conception’ of therapy. The book that remains the single most widely read of all of Rogers’ writings, *On Becoming a Person* (Rogers 1961), is a compilation of talks and papers produced during this phase.

In 1957, Rogers and several colleagues from Chicago were given the opportunity to conduct a major research study based at the University of Wisconsin, investigating the process and outcome of client-centred therapy with hospitalised schizophrenic patients. Although this project triggered a crisis in a formerly close-knit team of colleagues (Barrett-Lennard 1979; Kirschenbaum 2007), it did generate a wide range of new ideas (Rogers et al. 1967), including instruments for assessing concepts such as empathy, congruence, and depth of experiencing acceptance (Barrett-Lennard 2014; Klein et al. 1986; Truax and Carkhuff 1967). Eugene Gendlin began to construct a model of the process of experiencing that was to have a lasting impact. The opportunity to work with highly disturbed clients, and the difficulties in forming therapeutic relationships with these clients, led many of the team to re-examine their own practice, and in particular to arrive at an enhanced appreciation of the role of congruence in the therapy process. Client-centred therapists involved in the project discovered that the largely empathic, reflective mode of operating, which had been effective with anxious college students and other clients at Chicago, was not effective with clients locked into their own private worlds. To make contact with these clients,

the therapist had to be willing to take risks in being open, honest, and self-disclosing (Rogers and Stevens 1968).

The end of the Wisconsin experiment also marked the end of what Barrett-Lennard (1979) has called the 'school' era in client-centred therapy. Up to this point, there had always been a definable nucleus of people around Rogers, and an institutional base, which could be identified as a discrete, coherent school of thought. After the Wisconsin years, the client-centred approach fragmented, as the people who had been involved with Rogers moved to different locations, and pursued their own ideas largely in isolation from one another. The extension of client-centred ideas to encompass groups, organisations, and society in general meant that it was no longer appropriate to view the approach as being about clients as such, and the term 'person-centred' came increasingly into currency as a way of describing an approach to working with larger groups as well as with individual clients (Mearns and Thorne 2013). Currently, person-centred therapy remains one of the most widely practised approaches in many countries, and its ideas and methods have been assimilated into many other models of practice.

## Theoretical framework of the person-centred approach

As with other mainstream approaches to therapy, such as psychodynamic and cognitive-behavioural, the person-centred approach encompasses a number of distinct yet overlapping groupings (Bohart 1995). Warner (2000a) and Sanders (2004) have described the person-centred approach as being similar to a therapeutic 'nation', comprising a number of 'tribes'. These 'tribes' include classical client-centred/person-centred therapy, focusing approaches, experiential therapy such as emotion-focused therapy, expressive therapy, pre-therapy, and some versions of existential therapy. There are three basic therapeutic principles that define membership of the person-centred nation. The first principle is that person-centred practitioners seek to create a *relationship* with clients that is characterised by a high degree of respect, equality, and authenticity. The client is regarded as the expert on their own life and problems, and it is within the context of a facilitative relationship that the person can come to identify and accept their own personal solutions to the challenges of life. The second key therapeutic principle is an assumption that it is particularly helpful to work with clients in ways that enable them to become more aware of their moment-by-moment or 'here-and-now' experiencing. The idea is that patterns of thought and feeling that are associated with difficulties in everyday life situations are being continually re-created, wherever the client might be, and that a willingness to enter the *now* provides the client and therapist with opportunities to learn about these patterns, and change them. Another way of looking at this form of therapeutic activity is to view it as *process*-oriented work – the concept of process is a central construct in all forms of person-centred practice. The third principle is that each individual is viewed as engaged in a process of personal growth, becoming, or actualisation. Human existence is characterised by directionality, striving, and agency that is expressed in many different forms of creative endeavour.

The concept of *experiencing* is absolutely central to the person-centred approach – the person is viewed as responding to the world on the basis of their flow of moment-by-moment experiencing. The concept of experience can be defined as an amalgam of bodily sensed thoughts, feelings, and action tendencies, which is continually changing. The person-centred approach therefore positions itself differently from cognitive-behavioural therapy, which makes a firm distinction between cognition and emotion, and psychodynamic theory, which makes a firm distinction between conscious and unconscious. Within the person-centred approach, cognition and emotion, and conscious/unconscious material, are always interwoven within the 'phenomenal field' (i.e. the flow of experiencing) of the person.

The person, in the person-centred approach, is viewed as acting to fulfil two primary needs: the first is the need for self-actualisation; the second is the need to be loved and valued by others. Both

these needs are, following Maslow (1943), seen as being independent of biological survival needs. The person is very much seen as an embodied being, through the concept of 'organismic valuing' (i.e. the person has an inner embodied sense of what is right or wrong for them).

The idea of the *self-concept* is another key person-centred concept. The self-concept of the person is understood as those attributes or areas of experiencing about which the person can say 'I am . . .'. For example, a client in therapy may define themselves in terms such as 'I am strong, I can be angry, I sometimes feel vulnerable'. For this person, strength, anger, and vulnerability are parts of a self-concept, and when they feel vulnerable, or angry, there will usually be a *congruence* between feelings and the resulting words and actions. But if this person does not define themselves as 'nurturing', and is in a situation where a feeling of care or nurturance is evoked, they will not be able to put that inner sense or feeling accurately into words, and will express the feeling or impulse in a distorted or inappropriate way. Someone who is not supposed to be nurturing may, for instance, become very busy 'doing things' for someone who needs no more than companionship, comforting, or a human touch. Where there is a disjunction between feelings and the capacity for accurate awareness and symbolisation of these feelings, a state of *incongruence* is said to exist. Incongruence is the very broad term used to describe the whole range of problems that clients bring to counselling.

Why does incongruence happen? Rogers argued that, in childhood, there is a strong need to be loved or valued, particularly by parents and significant others. However, the love or approval that parents offer can be conditional or unconditional. In areas of unconditional approval, the child is free to express their potential and accept inner feelings. Where the love or acceptance is conditional on behaving only in a certain way, and is withdrawn when other behaviour or tendencies are exhibited, the child learns to define themselves in accordance with parental values. Rogers used the phrase *conditions of worth* to describe the way in which the self-concept of the child is shaped by parental influence. In the earlier example, the person would have been praised or accepted for being 'useful', but rejected or scorned for being 'affectionate' or 'soft'. Incongruence, therefore, results from gaps and distortions in the self-concept caused by exposure to conditions of worth.

The notion of *locus of evaluation* explains how the self-concept is created and how it changes. Rogers observed that, in the process of making judgements or evaluations about issues, people could be guided by *externally* defined sets of beliefs and attitudes, or could make use of their own *internal* feelings on the matter, their *organismic valuing process*. An over-reliance on external evaluations is equivalent to continued exposure to conditions of worth, and is associated with seeking to conform and to please others. In contrast, one of the goals of person-centred therapy is to help the individual to accept and act on their own personal, internal evaluations. Rogers had a positive and optimistic view of humanity, and believed that an authentic, self-aware person would make decisions based on an internal locus of evaluation that would be valid not only for themselves, but for others too. Although it is perhaps not explicitly articulated in his writings, his underlying assumption was that each person carried a universal morality, and would have a bodily sense of what was right or wrong in any situation.

The person-centred theory of the self-concept suggests that the person possesses not only a concept or definition of self 'as I am now', but also a sense of self 'as I would ideally like to be'. The 'ideal self' represents another aspect of the consistent theme in Rogers' work concerning the human capacity to strive for fulfilment and greater integration. One of the aims of person-centred therapy is to enable the person to move in the direction of their self-defined ideals.

A distinctive feature of person-centred theory is an explicit attempt to describe the *fully functioning* person. The main features of the fully functioning person were described by Rogers (1963) as: a capacity for openness to experience, engaging in a process of being and becoming, an ability to live in the moment, using feelings to guide action, and being autonomous rather than dependent on others. While these ideas are clearly grounded in the cultural milieu in which Rogers lived and worked, they have also proved to be sufficiently universal to be applicable (with some adaptation) in most cultures.

### Box 10.1: The enduring influence of Carl Rogers

Anniversaries of various key publications of Carl Rogers have stimulated the counselling and psychotherapy profession to engage in a reappraisal of the continued influence and relevance of his ideas, with major review articles on the general legacy of Rogers, by Hill and Nakayama (2000) and Orlinsky and Rønnestad (2000), and a cluster of papers revisiting the significance of the Rogers (1957) 'necessary and sufficient conditions' paper (Brown 2007; Elliott and Freire 2007; Farber 2007; Goldfried 2007; Hill 2007; Lazarus 2007; Mahrer 2007b; Samstag 2007; Silberschatz 2007; Wachtel 2007; Watson 2007). On the whole, these commentaries confirm the continuing relevance of client-centred ideas and methods. The only contemporary theorist who argues that Rogers got it *wrong* is Mahrer (2007b). The feminist psychotherapist Laura Brown (2007: 258) reflects a general theme in contemporary perspectives on client-centred theory in observing that 'much of what Rogers proposed 50 years ago remains true today'. Orlinsky and Rønnestad (2000) document the extent to which the currently highly influential concept of the 'working alliance' owes to the original formulation by Rogers of the characteristics of the facilitative relationship. On the other hand, the majority of these commentators also argue that there are significant factors that are missing in Rogers' writings, for instance an appreciation of the different requirements of clients with different preferred modes of feeling and problem-solving (Lazarus 2007; Silberschatz 2007), and an appreciation of the realities of social power and control (Brown 2007). It is striking that the critiques of Rogers' ideas that are put forward in the early years of the twenty-first century are broadly similar to the critiques that were published in the 1940s (see Hill and Nakayama 2000).

### The therapeutic relationship

Person-centred therapy is a relationship therapy. It starts from a position that individuals with emotional 'problems in living' have been involved in relationships in which their experiencing was denied, defined, or discounted by others, and that what is healing is to be in a relationship in which the self is fully accepted and valued. The characteristics of a relationship that would have this effect were summarised by Rogers (1957) in his formulation of the 'necessary and sufficient conditions of therapeutic personality change', which postulates that:

For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time:

- 1 Two persons are in psychological contact.
- 2 The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
- 3 The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
- 4 The therapist experiences unconditional positive regard [acceptance] for the client.
- 5 The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
- 6 The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

No other conditions are necessary. If these six conditions exist, and continue over a period of time, this is sufficient. The process of constructive personality change will follow.

This formulation of the therapeutic relationship has subsequently become known as the ‘core conditions’ model. It specifies the characteristics of an interpersonal environment that will facilitate actualisation and growth.

The three ingredients of the therapeutic relationship that have tended to receive most attention in person-centred training and research are the counsellor qualities of acceptance, empathy, and genuineness.

The core conditions model represented an attempt by Rogers to capture the essence of his approach to clients, in the form of a theoretical proposition. It also represented a bold challenge to other therapists and schools of thought, in claiming that these conditions were not just important or useful, but sufficient in themselves. The view that no other therapeutic ingredients were necessary invited a head-on confrontation with psychoanalysts, for example, who would regard interpretation as necessary, or behaviourists, who would see techniques for inducing behaviour change as central. The model stimulated a substantial amount of research, which has broadly supported the position taken by Rogers. In the person-centred approach there continues to be considerable debate over the accuracy and comprehensiveness of the necessary and sufficient conditions model. Indeed, Rogers (1961: chapter 3) himself described a much longer list of characteristics of a helping relationship, encompassing such constructs as ‘trustworthiness’, ‘personal strength’, and ‘sensitivity’.

## Empathy

The importance attributed to therapist empathy is one of the distinguishing features of the person-centred approach to counselling and psychotherapy. For the client, the experience of being ‘heard’ or understood leads to a greater capacity to explore and accept previously denied aspects of self.

The early phase of research and theory-building within the person-centred community, around the concept of empathy, had identified some puzzling findings. For example, when researchers attempted to measure the levels of empathic responding exhibited by counsellors, they found that ratings carried out from different points of view produced different patterns of results. A specific counsellor statement to a client would be rated differently by the client, the counsellor, and an external observer (Kurtz and Grummon 1972). It was also difficult to get raters to differentiate accurately between empathy, congruence, and acceptance: these three qualities all appeared to be of a piece in the eyes of research assistants rating therapy tapes. Finally, there were philosophical difficulties arising from alternative interpretations of the concept. Rogers characterised empathy as a ‘state of being’. In contrast, Truax and Carkhuff (1967) defined empathy as a communication skill, which could be modelled and learned in a structured training programme.

Many of these issues associated with the concept of empathy were addressed in the ‘empathy cycle’ model proposed by Barrett-Lennard (1981):

- Step 1: *Empathic set by therapist.* The client is actively expressing some aspect of their experiencing; the therapist is actively attending and receptive.
- Step 2: *Empathic resonance.* The therapist resonates to the directly or indirectly expressed aspects of the client’s experiencing.
- Step 3: *Expressed empathy.* The therapist expresses or communicates their felt awareness of the client’s experiencing.
- Step 4: *Received empathy.* The client attends to the therapist sufficiently to perceive the therapist’s immediate understanding.
- Step 5: *The empathy cycle continues.* The client then continues or resumes self-expression in a way that provides feedback to the therapist concerning the accuracy of the empathic response and the quality of the therapeutic relationship.

In this model, empathy is viewed as a process that involves intentional, purposeful activity on the part of the therapist. It can be seen that the perceptions of different observers reflect their tendency to be aware of what is happening at particular steps in the process rather than others. The therapist



will consider themselves to be in good empathic contact with the client if they are 'set' and 'resonating' in response to what the client has expressed (Steps 1 and 2). An external observer will be most aware of the actual behaviour of the therapist (expressed empathy – Step 3). The client, on the other hand, will be most influenced by the experience of 'received' empathy (Step 4). Barrett-Lennard's (1981) model also makes sense of the definition of empathy as communication skill or way of being. In so far as the therapist needs to be able to receive and resonate to the expressed feelings of the client, empathy is like a state of being. But in so far as this understanding must be offered back to the client, it is also a communication skill.

Barrett-Lennard's empathy cycle model has led to important new insights about how to facilitate empathic connection. For example, it describes a process that involves the therapist being congruently aware of their inner feelings and using their imagination and creativity (Duffey and Haberstroh 2013; Neukrug et al. 2013).

An important development in relation to empathy has been to examine the *impact* of accurate, well-timed, and sensitive empathic responses. Vanaerschot (1990, 1993) examined the therapeutic 'micro-processes' that were facilitated by effective empathic responses. These include: feeling valued and accepted; feeling confirmed in one's own identity as an autonomous, valuable person; learning to accept feelings; reduction in alienation ('I am not abnormal, different, and strange'); learning to trust and get in touch with one's own experiencing; cognitive restructuring of chaotic experiencing; and facilitating recall and organisation of information. Bohart (2004) argues that these processes arise from active client participation in empathy, which involves making productive use of what is offered by the therapist. In a qualitative study, clients who were interviewed around their experience of therapist empathy described a range of ways in which this process not only enhanced the quality of their relationship with their therapist, but also had a direct effect on self-insight and well-being (MacFarlane et al. 2017). The results of a study by Bohart et al. (1993) suggested that it can be particularly helpful to employ empathic reflections that are future-oriented and make links between current concerns and future directions and intentions. Analysis of how Carl Rogers actually responded to clients, in recorded therapy sessions, has also contributed to an appreciation of the potential diversity of ways in which empathy can be expressed (Brink and Farber 1996; Farber et al. 1996). Many studies have confirmed that skilful and sensitive therapist empathy is associated with good therapy outcomes (Elliott et al. 2018; Watson et al. 2014).

## Congruence and presence

In practice, possibly the single most distinctive aspect of the person-centred approach to therapy lies in the emphasis that is placed on therapist congruence. The influence of Rogers' ideas has meant that person-centred ideas and practices around empathy, self, therapeutic relationship, and experiencing have entered the vocabularies of many other approaches. However, few other approaches give as much importance to the realness, genuineness, authenticity, and willingness to be known of the therapist as do person-centred therapy and other contemporary humanistic therapies. Lietaer (1993, 2001) gives a valuable account of the evolution of the concept of congruence in Rogers' writings. Congruence was defined by Rogers (1961) as occurring when the feelings the therapist is experiencing are available to them, in their awareness, and they are able to use those feelings to inform their response to the client, including overtly communicating them if appropriate. Rogers (1961) added that while it is never possible to be fully congruent, it is essential for therapists to be able to take account of, and accept, their own feelings during a session. Barrett-Lennard (2014) identified *willingness to be known* as an important element of congruence. Towards the end of his career, Rogers (1980) used the term *presence* to describe this aspect of his work (Geller and Greenberg 2011; Rogers 1980). Grafanaki and McLeod (1999, 2002) characterised moments of congruence as comprising client and therapist engagement in a process of mutual flow that involved being fully present to each other at the same time. [Further discussion of the meaning of therapist congruence can be found in Gendlin (1967), Mearns and Thorne (2013), and Wyatt (2001).]



Why is congruence therapeutic? In what ways is it helpful for clients to work with a counsellor who is congruent, genuine, present, and willing to be known? Therapist congruence can have a number of valuable effects on therapy:

- it helps to develop trust in the relationship;
- if the therapist expresses and accepts their own feelings of vulnerability and uncertainty, then it becomes easier for the client to accept their own;
- it models one of the intended outcomes of therapy (straightforward, honest relating to others);
- if cues from speech, tone, and gesture are unified or consistent, then communication is clearer and more understandable;
- the therapist is able to draw upon unsaid or 'subvocal' (Gendlin 1967) elements in the relationship;
- it can facilitate the positive flow of energy in the relationship;
- tentative, nuanced expression of feelings on the part of the therapist helps the client to learn to tune into the complexity of their own experiencing.

By contrast, if a therapist is consistently incongruent, the client is likely to become confused, and lack confidence in the therapy relationship as a safe place within which they might explore painful or shameful experiences. On the whole, clients seek counselling because the other people in their life have responded to their 'problems in living' in a silencing, judgemental manner. An important factor in the possibility of therapy making a difference is the client's belief that their therapist is really listening, and really accepts them as a person, and that there is no hidden condemnation waiting to be unleashed. If a therapist appears to be open and genuine, but then tenses up or seems preoccupied whenever the client touches on a sensitive subject, without offering any explanation, then the chances are that the client will learn that this subject is 'out of bounds' for the therapist, and not to be broached.

### Box 10.2: Non-directiveness – a troubled concept

In his early writings, Carl Rogers used the term 'non-directive' to emphasise the idea that, in his new approach to therapy, the counsellor would follow the lead of the client rather than adhering to a pre-determined agenda. However, this idea was soon regarded by Rogers and his colleagues as contributing to potential misunderstanding of their practice, in so far as it defined their method as an 'absence' (rather than emphasising what it was striving to achieve), and because the concept of non-directiveness tended to trigger unhelpful debates around the impossibility of being with another person without influencing them. There has been considerable debate within the person-centred professional community around the usefulness of the concept of 'non-directiveness' (Bozarth 2002; Kahn 1999; Levitt 2005; Merry and Brodley 2002; Sommerbeck 2002). In the meantime, the term 'non-directive' has been adopted within the field of psychotherapy research as a means of characterising person-centred therapy as a passive or 'supportive' approach that does not offer active interventions (see, for example, Cuijpers et al. 2012; Kuerbis et al. 2018).

## The therapeutic process

From a person-centred perspective, the process of therapeutic change in the client is described in terms of a gradual process of greater openness to experience. Rogers (1951) characterised the direction of therapeutic growth as including increasing awareness of denied experience, movement from

perceiving the world in generalisations to being able to see things in a more differentiated manner, and greater reliance on personal experience as a source of values and standards. Although these developments lead to changes in behaviour, the 'reorganization of the self' (Rogers 1951) is seen as a necessary precursor to any new behaviour.

Rogers (1961) conceptualised the process of change as proceeding through a series of stages, which were further elaborated by Gendlin (1974) and Klein et al. (1986) and the concept of 'depth of experiencing'. In successful therapy, the client is viewed as becoming able to process information about self and experiencing at greater levels of depth and intensity (Rogers 1961; Klein et al. 1986). For example, at the start of therapy, a client may talk in an impersonal, detached manner in which their problems are attributed to the actions of other people. In response to therapist empathy and acceptance, the client becomes able to share more of their inner personal thoughts and feelings. Finally, a client may become capable of reflecting on and processing their own here-and-now emotional responses, which allows them to deal flexibly and constructively with situations that were previously experienced as threatening. On the basis of research evidence, Rogers (1961) argued that this kind of shift in capacity to process lived experience was irreversible.

## Experiential focusing

An important framework that is widely employed in the person-centred approach as a means of understanding process is Gendlin's model of experiential focusing, perhaps the most influential development in contemporary person-centred theory and practice (Lietaer 1990). The technique of focusing and the underlying theory of experiencing are supported by thorough philosophical analysis (Gendlin 1962, 1984a) and considerable psychological research (Gendlin 1969, 1984b).

The focusing process is built on the assumption that the fundamental meanings that events and relationships have for people are contained in the 'felt sense' experienced by the person. The felt sense is an internal, physical sense of the situation. In this inner sense, the person knows there is more to the situation than they are currently able to say. According to Gendlin (1962), this 'inner referent' or felt sense holds a highly differentiated set of implicit meanings. For these meanings to be made explicit, the person must express the felt sense in a symbol, such as a word, phrase, statement, image, or even bodily movement. The act of symbolising an area of meaning in the felt sense allows other areas to come to attention. Accurate symbolisation therefore brings about a 'shift' in the inner felt sense of a situation or problem.

Gendlin took the view that the experiential process described here is at the heart of not only person-centred therapies but all other therapies too. He regarded the therapeutic movement or shifts brought about by interpretation, behavioural methods, gestalt interventions, and so on to be reducible to episodes of effective experiential focusing. This experiential process is also a common feature of everyday life. The problems that bring people to counselling or psychotherapy are caused by an interruption of the process, an unwillingness or inability of the person to achieve a complete and accurate picture of the felt sense of the problem. The basic tasks of the counsellor are therefore to help the client to stay with the inner referent rather than avoiding it, and to facilitate the generation of accurate symbols to allow the expression of implicit meanings.

The process of 'focusing on a problem' can be broken into a number of stages or steps:

- 1 Clearing a space. Taking an inventory of what is going on inside the body.
- 2 Locating the inner felt sense of the problem. Letting the felt sense come. Allowing the body to 'talk back'.
- 3 Finding a 'handle' (word or image) that matches the felt sense.
- 4 Resonating handle and felt sense. Checking symbol against feeling. Asking 'does this really fit?'
- 5 A felt shift in the problem, experiencing either a subtle movement or 'flood of physical relief'.
- 6 Receiving or accepting what has emerged.
- 7 Stop, or go through process again.

These steps can occur, or be helped to occur, in the dialogue or interaction between therapist and client, or the therapist can intentionally instruct and guide the client through the process using a structured protocol. Leijssen (1993, 1998) has provided valuable accounts of how she integrates the use of experiential focusing into a conventional person-centred therapy session with a client. The technique has been taught to clients and used in peer self-help groups. Cornell (1993) reviews the issues involved in teaching focusing. Guidelines on how to learn practical skills in experiential focusing can be found in Gendlin (1981, 1996) and Cornell (1996). Comprehensive accounts of all aspects of the use of experiential focusing in counselling and psychotherapy can be found in Madison (2014) and Purton (2004).



### **Case study 10.1: Experiential focusing – the case of Sonia**

Sonia, in session 24 of therapy, felt tense, even though it was the first day of her holidays. At the start of the session, she described herself as ‘having an awful lot of things to do’. The therapist understood this statement as indicating, in terms of focusing theory, that Sonia was ‘too close’ to her problems to be able usefully to explore her ‘felt sense’ of any one of them. The therapist then initiated a simple strategy for ‘clearing a space’ within which Sonia could gain a clearer sense of what were the main issues for her. The therapist invited Sonia to write down her concerns on pieces of paper, and place the pages – and thus the problem – somewhere in the room that was a comfortable distance from where she was sitting. Sonia wrote and placed notes referring to each of her concerns – the carpenter coming to do some work, the heating system needing fixing, washing curtains, making an appointment with her dentist, talking to her cleaning lady . . . her loneliness, facing up to her father. In this way, Sonia was enabled to step back from what had seemed an overwhelming inner pressure, and to clear an emotional space in which she could discover that the underlying issue making her tense at the beginning of her holiday was that she no longer had an excuse to avoid visiting her father. She was then ready to look more closely at how she felt about this specific issue.



### **Case study 10.2: Using experiential focusing in a therapy session – the case of Oskar**

Oskar was a client who tended to talk about past events in a highly rational way. He was consistently ‘too far’ from his feelings to be able to focus effectively on any specific issue in his life. In one session, he told a long story about how he ‘thinks’ he ‘should’ feel angry with someone he knows. His therapist noted that although Oskar described himself as furious, he did not appear to be in contact with his actual feelings. She asked him to take a few moments to close his eyes and be aware of what was happening in his body, starting from the feet up. Oskar reported a powerful feeling of tension in the pit of his stomach. The therapist asked him to focus his awareness on whether anything else might come out of that feeling. He described something wanting to jump out, ‘like a devil out of a box’. There was a feeling of hate, accompanied by a feeling of power. He then talked about how he typically withdrew from a friend who had often hurt him, but now felt able to confront that person: ‘I won’t let myself be pushed aside any more’.

These case vignettes are taken from Leijssen (1998), who provides a detailed analysis of the experiential processes that are involved in each case. It is worth noting that, although the therapist in these cases is clearly following a focusing approach, she is also drawing upon a wide range of skills and

competencies that can be found in other therapeutic approaches – for example, the use of empathic reflection, metaphor and symbol, ritual, and externalisation. The difference lies in the fact that, here, the therapist is employing all of these skills with reference to the bodily felt sense of the client (and her own felt sense in relationship with the client), with the aim of exploring and unfolding the implicit meanings that are held in bodily feeling.

### Box 10.3: Is person-centred therapy culturally specific?

Person-centred theory does not make any specific reference to the significance of cultural factors, and person-centred practice does not usually include any kind of accommodation to different cultural values and behaviours. Furthermore, many commentators have observed that the optimism, egalitarianism, and focus on the individual self, which are central aspects of the person-centred philosophy, are highly characteristic of mid-twentieth-century American culture, and as a result the approach inevitably lacks relevance and resonance for people from other cultural groups (MacDougall 2002). The case of the adoption of the person-centred approach in Japan provides an alternative perspective on the way that a therapy approach can be applied in a cultural setting that is radically different from the one in which it was originally developed.

Hayashi et al. (1998) explain that the Japanese psychologist Fujio Tomoda discovered the writings of Carl Rogers in 1948, and was immediately convinced that they had a great deal to offer in his home country. He later studied with Rogers in Chicago, and translated many of Rogers' books and articles into Japanese. However, in the process of using person-centred ideas with a range of client groups in Japan, and running training courses, Tomoda and his colleagues began to evolve a version of person-centred counselling that was essentially Japanese in orientation. For example, Tomoda argued that envisaging self in terms of the idea of a *self-concept* ran the risk of failing to capture the specific cultural meaning of an entity that, in Japanese culture, would be understood in a more ambiguous way, as something that can ultimately never be put into words. Tomoda argued that moments of change occurred when the person is able to be 'utterly alone', and that it is the task of the counsellor to be an empathic partner who can handle the 'inner strangers' who are 'restraining the person's mind' and allow the person to arrive at a state of alone-ness where self-realisation was possible. These ideas were further articulated in a distinctive approach to training that incorporated the use of Japanese traditional *renku* poetry.

The adoption of person-centred ideas in Japan, and their development over a more than 70-year period, shows that the use of a therapy approach by practitioners in diverse cultural settings is more than just a matter of imposing ideas and methods from one culture to another. Ideally, the use of therapy ideas across cultures should involve a fusion of cultural horizons, where each set of participants learns from, and is changed by, the other (Lago and Charura 2016).

## Further developments in person-centred theory and practice

The bedrock of person-centred theory is based on the set of ideas, introduced in the previous section of this chapter, that were generated by Rogers and his colleagues in a highly productive period up to the mid-1960s. The classic 'manual' of person-centred practice written by Mearns and Thorne (2013) is largely based on this early body of knowledge. These foundational ideas have been debated and elaborated by many writers and researchers. However, as the level of interest in the person-centred approach has continued to grow, a number of influential new ideas also began to emerge, which have now achieved widespread acceptance across most of the person-centred community. The key

concepts that have been brought forward during this time are: agency, self-multiplicity, relational depth, mutuality, strategies of disconnection, difficult process, and post-traumatic growth. These ideas are now discussed in turn.

## Agency

The concept of agency is a philosophical term that refers to the human capacity for intentionality and purpose. In the context of therapy, the notion of client agency has been used as a means of drawing attention to the ways in which clients are actively involved in finding and applying their own strategies for dealing with problems in living, and, in therapy, make choices around how they will make use of therapist ideas and interventions that are offered to them. Within the person-centred approach to counselling and psychotherapy, the significance of client agency has been highlighted in the work of Art Bohart and David Rennie. The book *How Clients Make Therapy Work: The Process of Active Self-Healing* (Bohart and Tallman 1999) represented a major breakthrough in person-centred and humanistic therapies, in its careful and detailed exploration of different dimensions of client agency. The implications of this perspective have been further articulated in a series of publications, summarised in Bohart and Tallman (2010) and Bohart and Wade (2013), and in an autobiographical account (Bohart 2015). In a series of qualitative studies of the client's experience of therapy, Rennie (2000b, 2001) provides a wide range of specific ways in which clients retained conscious control of the process of therapy. Further qualitative research by Gibson and Cartwright (2013) and Hoener et al. (2012) has provided further evidence of the significance of this aspect of therapy.

Although the concept of personal agency was implicit in the writings of Rogers and other pioneers of person-centred therapy, the intellectual context in which they operated made it hard for them to focus explicitly on this phenomenon. For example, the 'necessary and sufficient conditions' conceptualisation of the therapeutic relationship positions the client as a largely passive recipient of the therapist's empathy, acceptance, and congruence, rather than seeing them as engaged in an active process of co-construction. Contemporary theory and research in the area of client agency has had the effect of sensitising person-centred therapists to this crucial aspect of the healing process.

## Self-multiplicity

The idea that there exist different 'parts' of the self, representing separate aspects of the experience or identity of a person, has been central to the practice of a number of different approaches to therapy, ranging from object relations theory to transactional analysis and gestalt therapy. However, Carl Rogers tended to describe the self as, essentially, a unitary structure that may shift in the direction of growth, fulfilment, and self-actualisation, but is not characterised by internal conflict. Mearns and Thorne (2000) have revisited this aspect of person-centred theory, and have argued that there has always been an implicit 'self-split' in the way that person-centred practitioners and theorists view the self. The split is between the 'growthful' part of the self and the 'not-for-growth' part. Mearns and Thorne (2000) use the term 'configurations' to describe these parts, to emphasise the individual, active, and changing nature of the person's process in relation to these elements of the self. They draw out some of the implications of this new perspective for the practice of person-centred counselling, particularly in relation to the need for the counsellor to accept and empathise with each 'configuration', rather than favouring the vulnerable 'growing' parts of the self. From this standpoint, it is the living *dialogue* between parts of the self that constitutes growth. Their use of the term 'configuration' is intended to imply a sense of how self-plurality is experienced within therapy, as a separation of contrasting clusters of thought, feeling, and action *in the moment*; there is no assumption that configurations arise from permanent structures or 'parts' of the self.

A further example of how the concept of self-plurality has been articulated within the person-centred approach has been the work on the *inner critic* by a number of person-centred theorists (Stinckens et al. 2002a, 2002b, 2013). One of the themes in counselling with people who might

describe themselves as ‘depressed’ is that they frequently criticise their own thoughts, actions, and feelings, sometimes in a very harsh manner. With some clients, it can be helpful to understand these actions as comprising an ‘inner critic’, to enable the client to become more aware of this pattern as a specific ‘part’ of the self.

Finally, the work of Bill Stiles and his research group has established a valuable resource of research and practice around the idea that the self can be envisaged as a community of *voices*. Although the voice concept is intended as an integrative concept, applicable in all therapy approaches (Stiles 2002), it has been found to have particular relevance within the person-centred tradition (Stiles and Glick 2002). Other examples of self-pluralism within person-centred and experiential therapy practice can be found in Cooper et al. (2004).

## Relational depth

The ‘core conditions’ model proposed by Rogers (1957) has been a cornerstone of person-centred theory and practice for 50 years. Despite the undoubted value of this set of ideas, it can be argued that the ‘necessary and sufficient conditions’ described by Rogers (1957) represent a somewhat sparse description of the nature of the therapeutic relationship: even if the core conditions are valid, do they represent the final word in thinking about relationships in therapy? The counselling/psychotherapy field as a whole has largely incorporated Rogers’ ideas into the somewhat broader conceptualisation of the therapeutic relationship provided by Bordin’s (1979) *working alliance* model, which identifies three dimensions of relationship: bond, goals, and tasks. However, neither the core conditions nor working alliance model of the therapeutic relationship attempts to come to terms with a key question: what does a *really good* therapy relationship look like? They offer useful models of adequate, or good-enough, client–therapist relating. But, given that much research suggests that the quality of the therapeutic relationship is central to the effectiveness of therapy, it is worthwhile to seek to go further, and attempt to develop a more comprehensive understanding of what constitutes a highly productive therapy relationship.

From within the person-centred approach, one way in which this issue has been addressed has been through the concept of *relational depth* – a state of profound engagement and contact in which each person is fully real with the other, and in which there is an enduring sense of contact and connectedness between client and therapist (Knox et al. 2013; Mearns and Cooper 2017). The experience of relational depth, for both client and therapist, is typically described as ‘multi-faceted’ (Tangen and Cashwell 2016; Wiggins et al. 2012), incorporating the elements of love, connectedness, respect, intimacy, transcendence, vulnerability, and energy. It has been possible to identify a number of strategies that therapists can adopt to facilitate the emergence of relational depth: letting go of expectations and agendas; ‘knocking on the door’ of deeper experiences; being open to being affected by the client; transparency; and working in the here-and-now. A substantial programme of research has developed around the concept of relational depth (Knox and Cooper 2011; Knox et al. 2013; McMillan and McLeod 2006), including both qualitative studies and the validation of a relational depth inventory (Wiggins 2013).

## Mutuality

A further area in which the understanding of relational aspects of person-centred practice has evolved is that of the importance of *mutuality*. In line with mainstream psychological thinking, the ‘necessary and sufficient conditions’ model formulated by Rogers characterised the therapist and client as separate, autonomous individuals. However, further evidence from both research and practice, particularly from the Wisconsin study, highlighted the extent to which effective therapy relied on a sense of togetherness or shared experience. This idea, that strong therapeutic relationships are grounded in a sense of mutuality, has been reinforced by the work of the Austrian person-centred therapist Peter Schmid.

In a series of papers, Schmid (2001, 2007a, 2007b) has carried out a careful philosophical analysis of the meaning of relationships in therapy. The central theme within this analysis is that it limits the



potential of a relationship to consider it as taking place between two separate, individual persons. Schmid (2001) argues that an essential aspect of being human involves understanding and accepting a sense of the 'we' – there is a collective or shared reality that transcends the individual perceptions or lives of any one of us. To acknowledge the 'we' involves the therapist being open to the 'otherness' of the client, and seeking to establish a 'Thou–I' relationship (I realise myself through my effort and struggle to understand and be with you). For Schmid (2001, 2007a, 2007b), the aim of therapy is to engage in a dialogue in which each participant can be fully present to the other. This kind of agenda is intellectually, morally, and personally challenging, but for Schmid (2007a, 2007b) it underpins any possibility of relational depth and transformational change. More recently, this line of conceptual analysis has been further extended by Bazzano (2014), and a number of research studies have begun to map out the ways in which mutuality can be observed with the process of therapy (Grafanaki and McLeod 1999; Murphy and Cramer 2014; Murphy et al. 2012; Tickle and Murphy 2014).

## Strategies of disconnection

Relational depth and mutuality can be understood as comprising experiences of strong connection and closeness between therapist and client. One of the themes that emerges from studies of these phenomena is that, while each participant needs to make a purposeful commitment to this kind of closeness, there is also an important sense in which it lies outside of conscious control: it just happens. Many writers on relational depth and mutuality have therefore emphasised the value of a willingness to remain open to this dimension of relating. This implies that, on some occasions, the therapist or client (or both) may not be willing to be open. It is useful, therefore, to consider the ways in which connection and closeness may be avoided and prevented. For some person-centred therapists, the idea of *strategies of disconnection* has become a practical way of thinking about how the conditions for mutuality and relational depth may be maximised. So far, two studies have explored the ways in which therapist disconnection is triggered in therapy, the forms that it takes, and its possible impact on the process of therapy (Cooper and Knox 2018; Gross and Elliott 2017). The findings of these studies have generated detailed lists of potential strategies of disconnection, including such behaviours as pretending to be interested, humour, intellectualising, and many others. These attitudes and behaviours can potentially be monitored by therapists and discussed in supervision and training. It remains to be seen whether such activities will have the effect of enhancing the relational quality of client–therapist collaboration.

## Difficult process

From a person-centred perspective, it is useful to think about therapy in terms of the way that the person experiences the world, and the way that they process different elements of experience (thoughts, feelings, bodily phenomena, action tendencies). The idea of 'process', in this context, can be defined as an activity involving paying attention to, and regulating the intensity of, different facets of experiencing. Person-centred and humanistic therapists, of whatever 'tribe' they belong to, have always been trained to work with process. However, the models of process that have been used within the person-centred approach – for example, the Rogers (1961) and Klein et al. (1986) model of depth of experiencing, or the stages of experiential focusing model, both described earlier in this chapter – have always described a generalised process that would, in principle, be the same for any person in any situation.

In an important body of work, Margaret Warner has begun to develop a framework for understanding different *types* of experiential processing that are characteristic of people with different types of problem. She uses the term *difficult process* to encompass this set of ideas. Warner (2000a, 2002b) has described two main types of difficult process. *Fragile process* occurs when the person has difficulty in maintaining the flow of processing of experiential material. In fragile processing, the person may be unable to 'stay with' a thought or feeling that is problematic for them, with the result that the 'track' of their conversation is punctuated by silences or gaps – they get lost, or the

feeling that they were exploring seems to dissolve. *Dissociated process* occurs when the person abruptly shifts from one area of experiencing to another. For example, a person may be talking about a troubling episode in his relationship with his partner, then abruptly moves away from this topic, and starts to talk instead about how he feels about a painting on the wall of the counselling room. What has happened with this client could be interpreted as an example of a dissociative process in which he protected himself against potentially painful emotions and memories by refocusing his attention on something soothing and trivial – a safety procedure learned early in life.

Mearns and Thorne have described Warner's work as the most significant contribution of recent years. Mearns and Thorne (2013) themselves have identified a further example of difficult process. *Egosyntonic process* happens when a person is so afraid of social relationships that they consistently perceive all issues in terms of their pay-off for self (this is like being 'self-centred'). A further example of a different type of difficult process (as yet uncategorised) has been described by Warner (2002b) in her work with a man diagnosed as schizophrenic. The capacity to identify distinct patterns of difficult process in clients is only part of the problem: what does a counsellor do in response to such processes? Vanaerschot (2004) makes a powerful case for the view that difficult processes arise because of a failure of empathy in the early social world of the person, and that careful attention to empathic engagement and the use of pre-therapy strategies (Prouty et al. 2002) can make it possible for a person to begin to emerge from difficult process, and gradually to be able to engage more fully with all the aspects of their experiencing.

## Post-traumatic growth

Within the applied psychology literature, and in the field of counselling and psychotherapy practice, adverse and traumatic experiences are generally regarded as harmful, with negative psychological effects. From a person-centred and humanistic perspective, however, such events can be viewed as not only difficult and problematic, but also as opportunities for personal growth. The work of Stephen Joseph, in particular, has been instrumental in developing ways to apply person-centred concepts such as the actualising tendency, and therapeutic principles such as empathy and depth of experiencing, to address the experiences of individuals who have been exposed to traumatic events (Joseph 2004, 2011, 2015; Merriman and Joseph 2018; Murphy and Joseph 2014, 2015). This programme of research and practice development has incorporated studies of post-traumatic growth in people who have experienced trauma in a range of different situations (McCormack and Joseph 2013, 2014; Smith et al. 2011; Splevins et al. 2010) and the construction of interview schedules and questionnaires that assess positive well-being and growth (Longo et al. 2018).

The topics outlined before represent areas of major advance in person-centred theory and practice. It is worth noting that, in each of these areas, person-centred theorists have made considerable use of ideas from other approaches to counselling and psychotherapy, primarily from psychodynamic theory, social psychology, and developmental psychology. These innovative perspectives have yet to be fully integrated into mainstream person-centred theory and practice. Just as, in the 1950s, new concepts such as empathy and experiencing underwent thorough examination in the form of research and practice, these contemporary concepts are undergoing a similar process.

## Other humanistic therapies that build on the person-centred approach

The category of 'humanistic therapy' is generally understood as encompassing a wide range of models of therapy, including approaches that are discussed in other chapters of this book: gestalt therapy, transactional analysis, and existential therapy. The therapy approaches discussed in the following sections – expressive therapy, pre-therapy, emotion-focused therapy, and counselling for depression – represent humanistic therapies that are specifically grounded in person-centred ideas and methods.

## Expressive therapy

Natalie Rogers (1928–2015) was the daughter of Carl Rogers and continued his work in the context of art therapy (Klein 2013; N. Rogers 2000, 2016; N. Rogers et al. 2012). Many person-centred therapists have been trained in her methods and integrate her expressive techniques into their work with clients. Conceptually, person-centred expressive arts therapy is firmly based in the tradition of creating a therapeutic space in which the client experiences the ‘core conditions’. However, in addition, it also comprises an important extension of the ideas of Carl Rogers on the central significance of creativity in relation to having a satisfying and fulfilling life. Natalie Rogers introduced the concept of ‘creative connection’ to refer to the ways in which engaging in creative activity could make it possible for the person to access authentic aspects of self. Compared with other forms of art therapy, her approach is characterised by a reflective approach on the part of the therapist, that eschews any interpretation of the art work created by the client.

## Pre-therapy and contact work

The theory of ‘necessary and sufficient conditions’ proposed by Rogers (1957) has generally been interpreted as highlighting the importance of empathy, congruence, and unconditional positive regard as basic ingredients of a productive therapeutic relationship. Less attention has been given to the opening statement in Rogers’ model: ‘two persons are in psychological contact’. In most therapeutic encounters, it may be reasonable to take for granted the existence of a sufficient degree of basic psychological contact. No matter how anxious or depressed a person is, usually they will retain some capacity to take account of the psychological reality represented by whoever else is in their immediate proximity, whether this be a counsellor or someone else. However, there are some people for whom basic contact with another human being is hugely problematic. These may be people who have been damaged by life experiences, who are profoundly anxious, institutionalised or sedated, or who suffer from cognitive impairment. Persons regarded as schizophrenic or learning disabled may fall into this category. Few attempts have been made to provide therapy to clients from these groups. Within the person-centred approach, pioneering work was carried out at the University of Wisconsin by Rogers and his colleagues into the process and outcome of therapy with hospitalised schizophrenic patients (Rogers et al. 1967). Some of the learning from that study subsequently informed the ‘pre-therapy’ or ‘contact work’ model developed by Garry Prouty (1936–2009) (Prouty 1976, 1990; Prouty and Kubiak 1988; Prouty et al. 2002).

Rogers (1968: 188) wrote that the Wisconsin project taught him that schizophrenic individuals tend to ‘fend off’ relationships through silence or continuous talk. Prouty devised strategies for counteracting ‘fending-off’ by reflecting back to the client, in very simple ways, the therapist’s awareness of the client’s external world, self and feelings, and communication with others. The aim is to restore the client’s capacity to be in psychological contact and, as a result, to enable them to enter conventional therapy or take advantage of other types of therapeutic activity and social care. Examples of how this technique functions in practice can be found in a range of case-based reports (Courcha 2015; Dodds et al. 2004; Erskine 2015; Krietemeyer and Prouty 2003; Štěpánková 2015; Swan and Schottelkorb 2015; van Werde 1994, 2014).

Although pre-therapy and contact work has been mainly used with severely damaged and ‘hard-to-reach’ individuals, it is equally applicable during moments when more fully functioning individuals withdraw from the relationship. Pre-therapy draws on core person-centred principles of respect, acceptance, willingness to enter the frame of reference of the other, and belief in a process of actualisation. Further sources of information on pre-therapy and contact work include Peters (1999, 2005), Prouty (2008), and Sanders (2006).

## Emotion-focused therapy

A highly influential, research-informed development within the broad person-centred or humanistic tradition has been the approach to counselling and psychotherapy created, in the 1990s, by

Les Greenberg, Laura Rice, Robert Elliott, and others. This approach was originally described as process-experiential therapy (Greenberg et al. 1993) but has subsequently been 're-badged' as emotion-focused therapy (EFT) (Elliott et al. 2003; Greenberg 2002). The emotion-focused approach is an integration of ideas and techniques from person-centred and gestalt therapies, contemporary cognitive psychology, attachment theory, narrative therapy, and constructivist philosophy. One of the distinctive features of the approach is its emphasis on significant events within therapy sessions. Whereas Rogers' conditions of empathy, congruence, and acceptance refer to interpersonal processes – or a relationship environment – that occur throughout therapy, Greenberg and his colleagues have suggested that it can be useful to give particular attention to creating highly meaningful moments of change.

A central assumption in EFT is that the problems people have are based on an inability to engage in effective emotional processing. Emotions provide vital information about relationships, and are guides to action. When a person fails to express or communicate emotion, their capacity to interact with others is impaired. The goal of therapy is therefore to facilitate emotional processing, to enable the person to integrate how they feel into how they experience events and relationships, and how they make decisions. In order to accomplish this, the therapist needs to be highly attuned to the moment-by-moment immediate process through which the client expresses their thoughts and feelings, and engages with the therapist. As the client talks about their problems, they will communicate clues or *markers* to the therapist concerning blocked or distorted emotions (Watson 2010). The task of the therapist is to listen out for these markers and initiate an appropriate sequence of emotional processing.

An example of this kind of approach can be found in Rice's (1974, 1984) model of stages in the resolution of 'problematic incidents'. These are incidents in the client's life when they felt as though their reaction to what happened was puzzling or inappropriate. Rice (1984) has found that effective therapy in these circumstances tends to follow four discrete stages. First, the client sets the scene for exploration, by labelling an incident as problematic, confirming what it was that made the reaction to the incident unacceptable, and then reconstructing the scene in general terms. The second stage involves the client and counsellor working on two parallel tasks. One task is to tease out different facets of the feelings experienced during the incident; the other is to search for the aspects of the event that held the most intense meaning or significance. This second stage is centred on the task of identifying the meanings of the event for the client. In the third phase, the client begins to attempt to understand the implications for their 'self-schema' or self-concept of what has merged earlier. The final phase involves the exploration of possible new options. Rice (1984) describes this whole process as being one of 'evocative unfolding', in which the cognitive-affective reprocessing of a single troubling episode can lead into a widening series of self-discoveries.

Emotion-focused therapists have conducted a substantial amount of research into emotional processing tasks in counselling and psychotherapy, and have compiled protocols to guide therapists in working effectively with many different types of emotional processing event, including:

- systematic evocative unfolding at a marker of a problematic reaction point;
- experiential focusing for an unclear felt sense;
- two-chair dialogue at a self-evaluative split;
- two-chair enactment for a self-interruptive split;
- empty-chair work to resolve emotional 'unfinished business';
- empathic affirmation as a marker of intense vulnerability.

There is evidence of the effectiveness of process-experiential therapy for marital problems (Greenberg and Johnson 1988), depression (Elliott et al. 1990; Greenberg and Watson 2005; Greenberg et al. 1990), post-traumatic stress disorder (Elliott et al. 1996, 1998), social anxiety (Elliott and Shahar 2017), generalised anxiety disorder (Timulak et al. 2017), perpetrators of intimate partner

violence (Pascual-Leone et al. 2011), and individuals on the autism spectrum experiencing issues of loss and trauma (Robinson 2018; Robinson and Elliott 2016, 2017).

Two-chair work comprises a key intervention within EFT. In the opening phase of therapy, the aim is to use person-centred skills to develop a relationship within which the client can feel safe. The client is invited to engage in dialogue with a critical part of self, or a significant individual in their life, that they imagine sitting in an adjacent chair, and then to reply to self from that other position. While they are doing this, the therapist coaches them to speak from their feelings, and to express emotion towards the figure in the other chair. The assumption is the client will begin by expressing 'secondary' emotions, in the form of socially acceptable statements that represent secondary emotions, but that the intensity of the situation and the supportive presence of the therapist will make it possible for them gradually to express previously suppressed 'primary' emotions. Over time, a capacity to access and express primary emotions makes it possible for the person to have more energy for life, and to engage in more authentic ways of relating to others.

Considerable research has been conducted into the therapeutic processes that are associated with effective two-chair work in EFT. Stiegler et al. (2018b) found that when emotion-focused two-chair dialogue was introduced following several sessions where the therapist had used a person-centred approach, the more active intervention yielded better results than had been observed in the opening sessions. Qualitative studies in which clients were interviewed about their experience of two-chair work have found that while all clients initially found it embarrassing, confusing, or threatening to take part in the activity, the majority eventually reported that it was helpful (Lafrance Robinson et al. 2014; Stiegler et al. 2018a). However, a small number of clients in these studies were unable to make effective use of this intervention (see also the case analyses in Watson et al. 2007).

An important aspect of EFT research and practice has been its conceptualisation of therapy in terms of task sequences (Pascual-Leone and Greenberg 2007). Intensive analysis of transcripts of good outcome and poor outcome EFT cases has made it possible to distinguish between productive and unhelpful sequences of therapist and client actions in response to specific types of therapeutic work that need to be accomplished. In turn, this kind of framework makes it possible to train therapists in the observational and intervention skills required for each step of a productive task process.

Further development of the theory and practice of EFT increasingly reflects the work of Laco Timulak, Antonio Pascual-Leone, and their colleagues (O'Brien et al. 2017; Timulak 2015; Timulak and McElvaney 2016; Timulak and Pascual-Leone 2015; Timulak et al. 2017). While retaining the basic conceptual framework of classical EFT, they have reformulated it in terms of more experience-near language. Rather than a formal model based on emotion schema, there is an increasing use of terminology such as 'emotional pain' and 'unmet needs'. Emotional pain is viewed as comprising a mix of shame-based, loneliness-based, and fear-based experiences. These dimensions of experience make it possible for therapists to enrich their understanding by making connections between EFT and other psychotherapy models such as attachment theory (fear of being abandoned, loss of a loved one). They also allow the therapist to contextualise emotional pain in respect of the specific life experiences of the client and invite the therapist to reflect on what they can do to soothe the client, and convey caring, to allow such painful emotions to be bearable and therefore capable of being expressed. The ultimate goal of such therapy is to enable the client to make use of self-compassion to counteract harsh self-criticism that was associated with painful life experiences, to become able to self-soothe, and to channel self-protective anger in the face of adversity and abusive relationships. Another important line of current development has been the integration of a narrative perspective into EFT (Angus 2012; Angus and Greenberg 2011; Goldman and Greenberg 2015). The value of this work has been to sensitise the therapist to the ways in which the client uses different modes of storytelling to enter into states of emotion, and then to shift into reflection on what they have felt.



Emotion-focused therapy is a well-established approach to therapy, supported by substantial research evidence and a thriving international training programme. Many person-centred (and other humanistic) therapists have sought further training in EFT, as a means of building on and extending core person-centred skills and awareness. A commitment to innovation has resulted in adaptations of EFT for clients with eating disorders (Brennan et al. 2014) and interpersonal issues associated with autism (Robinson and Elliott 2016, 2017), as well as in other areas of practice. Conceptually, and in practice, while EFT shares many features with person-centred therapy, the therapist takes a much more explicitly active role in EFT, and the process of EFT is oriented around the facilitation of discrete change events rather than a gradually evolving development of self-acceptance. In studies that have compared these models, although EFT comes out as being slightly more effective, the difference is marginal (Goldman et al. 2006). It is also possible that the greater emotional intensity of EFT may be off-putting for some clients.

### **Humanistic counselling**

Humanistic counselling, also described as person-centred experiential therapy (Nye et al. 2018), refers to an integration of ideas and techniques from person-centred therapy and EFT that has been developed in Britain in response to government demands for a manualised, evidence-based counselling alternative to CBT and psychodynamic therapy. At the present time, humanistic counselling has been studied in two contexts: in work with adult depressed clients (Drewitt et al. 2018; Sanders and Hill 2014; Saxon et al. 2017) and in schools (Pearce et al. 2017; Pybis et al. 2014).

## **Links between the person-centred approach and other therapy traditions**

The person-centred and client-centred ideas and methods developed by Carl Rogers and his colleagues have been around for a long time and have been assimilated into many approaches to therapy. A survey by Thoma and Cecero (2009) found that therapists from all approaches make use of person-centred skills and principles on a routine basis. Both the movements to promote person-centred health and social care, and the use of motivational interviewing techniques in addictions, have been powerfully shaped by person-centred therapy. Person-centred concepts, such as empathy and the therapeutic relationship, can readily be connected to similar ideas within other therapy traditions such as the psychodynamic approach (Thorne and Sanders 2012). Despite this gradual fusion between person-centred and everything else, the person-centred approach remains a philosophically coherent, research-informed, and practically robust approach to therapy, which continues to grow and develop.

## **Conclusions**

The early phase of the development of the person-centred approach, particularly the 'Chicago' years (Barrett-Lennard 1979), represents a unique achievement in the history of counselling and psychotherapy (McLeod 2002). Between 1940 and 1963, Rogers and others evolved a consistent, coherent body of theory and practice that was informed and shaped by ongoing research, and which remains a powerful strand of thought. Further developments within the person-centred approach have resulted in both a deeper understanding of Rogers' key concepts, and an extension of the approach to embrace new concepts and areas of application. The person-centred approach has been applied in work with a wide range of client groups, and is supported by a substantial body of research that indicates levels of therapeutic effectiveness equivalent to that achieved by any other form of therapy, including CBT (Elliott et al. 2013; Mearns and Thorne 2013).





## Topics for reflection and discussion

- 1 How valid do you find the ‘necessary and sufficient conditions’ model? Are there other ‘conditions’ you would want to add to Rogers’ list?
- 2 What are the strengths and weaknesses of the person-centred approach compared with the psychodynamic and cognitive–behavioural approaches described in previous chapters?
- 3 Kahn (1997: 38) has written that: ‘Rogers spent forty years developing his view of therapy. And perhaps it would not be far off the mark to view his whole forty years’ work as an attempt to shape an answer to a single question: What should a therapist do to convey to a client that at last he or she is loved?’ In your view, how valid is Kahn’s assertion?
- 4 To what extent can EFT be seen as merely an extension of Rogers’ ideas? Are there ways in which EFT is in conflict with basic, non-negotiable person-centred ideas and assumptions? If they are, why does it matter?

## Suggested further reading

There is no substitute for reading the work of important original thinkers in the field of counselling and psychotherapy. Carl Rogers has been the dominant figure in the person-centred movement, and his key books, *Client-Centered Therapy* (Rogers 1951) and *On Becoming a Person* (Rogers 1961), remain as fresh and relevant as ever. Kirschenbaum and Henderson (1990) have brought together a collection of Rogers’ work from all phases of his career. A book that is a pleasure to read and conveys the spirit of the person-centred approach is *Dibs*, by Virginia Axline (1971), which offers an account of a version of client-centred play therapy carried out by Axline with a young boy, Dibs. More than any other piece of writing, *Dibs* communicates the deep respect for the person, and the capacity of the person to grow, that is so central to effective person-centred work. The range and scope of contemporary thinking around person-centred and experiential theory, research, and practice can be found in handbooks edited by Cain et al. (2016), Cooper et al. (2013), Cornelius-White et al. (2013), Joseph (2017), Lago and Charura (2016), and Wilkins (2015). Journals such as *Person-Centred and Experiential Psychotherapies*, *Journal of Humanistic Psychology*, *Journal of Humanistic Counseling*, and *The Humanistic Psychologist* attest to the ongoing relevance of the humanistic tradition.

# Chapter 11

## Transactional analysis: a comprehensive theoretical system

<b>Introduction</b>	<b>171</b>
<b>The theoretical foundations of transactional analysis</b>	<b>172</b>
Basic assumptions	173
Structural analysis	174
Analysis of transactions	176
Games	176
Life scripts	177
<b>Transactional analysis in practice</b>	<b>179</b>
<b>The organisational structure of transactional analysis</b>	<b>181</b>
<b>Using research to support new developments in TA therapy</b>	<b>182</b>
<b>Reflections on transactional analysis</b>	<b>182</b>
<b>Conclusions</b>	<b>183</b>
<b>Topics for reflection and discussion</b>	<b>183</b>
<b>Suggested further reading</b>	<b>184</b>

### Introduction

Transactional analysis (TA) is a social psychological theory, developed by the psychiatrist and psychoanalyst Eric Berne in the 1960s (Berne 1961/2001). Transactional analysis has been applied in a number of areas of social life: counselling and psychotherapy, education, and organisation and management studies. It is of particular interest to therapists because it represents a theoretical framework that is both comprehensive and integrative – TA is an invaluable source of concepts and ideas, even for those who do not use the approach directly in their practice. This chapter is organised

in two main sections. First, an overview is provided of the main elements of TA theory. Second, the application of these ideas in counselling is explored, in relation to four main traditions of TA practice. The chapter closes with some reflections on the strengths and weaknesses of the TA approach, and the contribution that it has made to the field of counselling and psychotherapy as a whole.

## The theoretical foundations of transactional analysis

Eric Berne (1910–1970) was born and brought up in Montreal, Canada, as Eric Lennard Bernstein. His father was a doctor and his mother a writer, both from Polish/Russian immigrant backgrounds. His father, with whom he had a close relationship, died in 1921. Berne qualified as a doctor and psychiatrist, and shortened his name when he moved to the USA and took up American citizenship in 1939. He worked in private practice and in the US Army before entering psychoanalytic training with Paul Federn and Erik Erikson, and made contributions to the psychoanalytic literature with his writing on intuition. He eventually settled in Carmel, California. He hosted a weekly seminar from 1951, in which the key ideas of what was to become his new approach were formulated. A key life event for Berne was the rejection of his application in 1956 for full membership of the San Francisco Psychiatric Institute, which stimulated him to develop his own model of therapy. Biographical accounts portray Berne as a man who was perhaps difficult to know, and who found it hard to sustain intimate relationships (Jorgensen and Jorgensen 1984; Stewart 1992).

Virtually all of the key ideas and principles of TA were generated by Berne and a group of close colleagues between 1958 and 1970. This was a time of great innovation more generally within the field of counselling and psychotherapy within the USA, particularly in relation to humanistic alternatives to psychoanalysis (e.g. the client-centred therapy of Carl Rogers). The theory and practice of TA that evolved during these years can be seen as representing a creative fusion of psychoanalytic and humanistic concepts and values, alongside some ideas from social psychology. It is important to note that most of Berne's clinical practice consisted of group psychotherapy, rather than individual therapy. Transactional analysis is probably the only mainstream therapy approach that has its origins in groupwork, and this explains the strong emphasis within the theory on understanding patterns of interaction between people, and on being able to observe the behavioural and non-verbal manifestations of underlying psychological states.

### Box 11.1: The radical tradition in transactional analysis

The period during which TA theory and practice was beginning to become established, the 1960s, was also a time of political upheaval, with protests against the Vietnam War, racism, and capitalist systems. This radical agenda had an impact on the development of TA through the influence of Claude Steiner, a close colleague of Eric Berne. From 1968, Steiner was a leading figure in the Radical Psychiatry group in the USA, a regular contributor to the journals *Radical Therapist* and *Issues in Radical Therapy*, and co-author of *Readings in Radical Psychiatry* (Steiner and Wyckoff 1975). The Radical Psychiatry Manifesto characterised individual psychotherapy as an 'elitist', 'outmoded', and 'unproductive' form of help and argued instead for the greater use of supportive work in groups. Further information about the Radical Psychiatry movement, together with its manifesto, is available on Steiner's website and in Steiner (2001). Many of these ideas found their way into TA practice, in the form of formulating theory in vivid, accessible language, an emphasis on working in groups, brief rather than extended therapy, collaborative contracting with clients, encouraging clients to learn therapy theory, a willingness to allow clients to read clinical notes, and the development of ways of understanding power differences between individuals and gender relationships (Steiner 1981).

Transactional analysis is distinctive, in contrast to other counselling/psychotherapy approaches, in that it is based on a formal set of theoretical propositions. While other approaches to therapy, such as person-centred/experiential, psychodynamic, and CBT, can also draw upon rich sets of concepts, the tendency in these approaches is for theory to be organised in terms of a loose net, with various strands of conceptualisation stretching out from ideas that were initially formulated by the founders of the model. Furthermore, in these mainstream approaches there can be a fair amount of disagreement over the interpretation and meaning of core concepts. Transactional analysis is not like that. There exists a unified theoretical framework that is summarised in a series of key texts (Joines and Stewart 2002; Stewart and Joines 2012; Woollams and Brown 1978). While the ideas that comprise this framework are elaborated in the pages of the *Transactional Analysis Journal*, and in books, there are no major theoretical conflicts around core concepts (compare this situation, for example, with the debates in psychoanalysis around the true meaning of countertransference, or the arguments in the person-centred tradition around the notion of non-directivity).

One of the reasons for the high degree of theoretical consensus within the TA world is because the theory itself is highly coherent. The theory is built around a set of basic assumptions, which are developed into specific models that can be applied to different levels of complexity in human interaction: the individual, the two-person dyad, group interaction, and the interaction between person and culture over a lifespan. A significant and distinctive feature of TA theory is concerned with the way that its ideas are expressed and communicated. Using colloquial terms and imagery whenever possible, rather than using abstract technical terminology, TA theorists have striven to develop 'experience-near' theory. They also make frequent use of diagrams to display the links between theoretical entities. The diagrammatic presentation of TA concepts allows complex interrelationships to be discussed without the danger of descending into over-abstruse and dense language.

## Basic assumptions

The concept or image of the person that is used in TA is ultimately grounded in three simple yet powerful ideas – one relating to human motivation, the other two relating to values. The motivational concept is the idea of *strokes*. A 'stroke' can be defined as an act of recognition of one person by another. The communication of acceptance and liking is 'positive' stroking; rejection, criticism, and discounting are forms of 'negative' stroking. The notion of stroking clearly has parallels with the concept of reinforcement, which is central to the operant/instrumental conditioning theory of learning espoused by B. F. Skinner. However, it also has parallels with existential ideas around affirmation and validation. One of the TA core concepts in the area of values is the idea of *OK-ness*. This idea refers to a basic attitude of acceptance of self and others. The preferred position in TA – or to put it in different terms, the recipe for a good life – is to interact with other people from an 'I'm OK, You're OK' stance. In other words, if a person can accept and affirm themselves, and also those other people with whom they are in contact, the possibilities for constructive, creative interaction are maximised. Adopting any of the alternative positions (i.e. 'I'm OK, You're not OK'; 'I'm not OK, You're OK'; 'I'm not OK, You're not OK') undermines the possibility of authentic relatedness in different ways (for instance, 'I'm OK, You're not OK' reflects rejection and belittling of the other; 'I'm not OK, You're OK' reflects avoidance of the other; and 'I'm not OK, You're not OK' reflects a depressive, hopeless attitude to life). The third basic assumption in TA refers to the value of different types of human action. This idea starts with the concept of *time structuring* – how do people use their time. From a TA perspective, there are six ways in which time can be structured: withdrawal, rituals, past-times, activity, psychological games, and intimacy. From a TA perspective, intimacy is intrinsically valuable and life-enhancing, as a mode of being with others.

These three core concepts (strokes, OK-ness, and time structuring) provide a readily accessible way of understanding the goals of TA – the function of TA theory and therapy is to enable the person to create the conditions in which intimacy can be possible, from an 'I'm OK, You're OK' position in which the person can give and receive positive strokes. The goal of TA therapy is achieved by learning about the many distinct ways in which individual psychology and social interaction can be

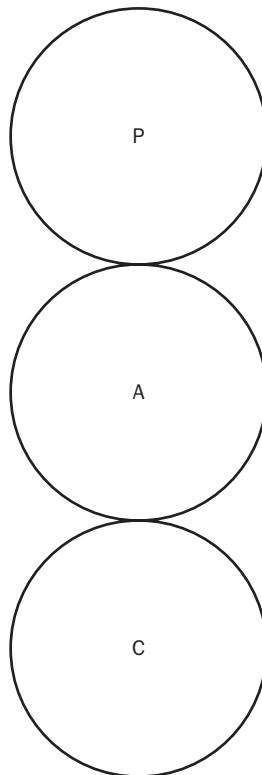
organised in order to avoid or deny intimacy and 'OK-ness'. The simple, yet powerful basic assumptions of TA theory reflect an image of human strength and mutuality that functions as a counter-balance, and source of hope, in contrast to the inevitable stories of dysfunction, hurt, and disorder that are told by people who seek therapy.

## Structural analysis

Structural analysis is the level of TA theory that attempts to make sense of the psychological functioning of the individual person. The TA perspective on personality is organised around the concept of the *ego state*, which can be defined as a pattern of thought, feeling, and action that represents a developmentally and functionally significant mode of relating to self and others. Transactional analysis theory specifies three main ego states – the Parent (P), Adult (A), and Child (C). The Parent ego state is the part of the personality that comprises rules and injunctions internalised from one's own mother and father, other significant figures during childhood, and the wider culture. The Adult ego state is understood to operate as the rational, decision-making function in the personality. The Child ego state represents emotional experience and creativity. Usually, these ego states are visually represented in a traffic light configuration (Figure 11.1).

It is worth reflecting on some of the implications of this particular configuration, in contrast to other possible ways that three circles might be displayed – for example, in a horizontal line, or in a triangle with each one touching the other. The vertical ordering of ego states chosen by Berne locates the Adult *between* Parent and Child. It also gives no possibility for direct contact between

**Figure 11.1** Structure of personality



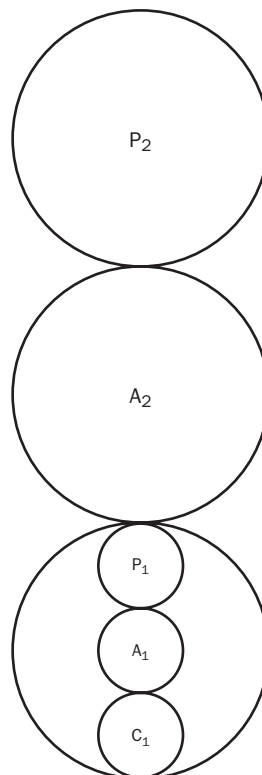
Parent and Child – their interaction is mediated by Adult. The parent appears, visually, to look over the other two ego states. Each of these factors has meaning in terms of embodying implicit aspects of the model.

The traffic light image makes it easy to begin to visualise some significant facets of individual functioning. For example, are the boundaries between the three circles fixed and impermeable (implying that the person cannot readily engage all three states in response to external demands, but may be quite rigidly stuck in one or another of the states)? Or the boundary may be porous – one ego state may be *contagious* and dominate the others (as when a person seems to approach all aspects of life from a critical, Parent, stance).

The depiction of the three ego states that has been considered so far is known as *first-order* structural analysis. It is also possible to envisage the Parent and Child ego states each subdivided into *second-order* structures. In other words, there is a hypothesised subsidiary Parent, Adult, and Child embedded within each of these primary ego states. Figure 11.2 represents the second order – Parent, Adult, and Child within the primary Child ego state.

The introduction of second-order structural analysis makes it possible to represent diagrammatically the early developmental experiences that have contributed to current ego state functioning. For example the Parent-in-the-Child can be understood as comprising ‘magical rules’ that the person has unquestioningly internalised from their early years, such as ‘if I don’t eat all my dinner, Mother will go away and leave me and never come back’ (Stewart and Joines 1987: 34). The Adult-in-the-Child has been described as a ‘Little Professor’, who generates intuitive, instance answers to problems, in

**Figure 11.2** Second-order structural analysis





the form of pseudo-rational responses. Finally, the Child-in-the-Child retains bodily memories of early experiences of pain and frustration, and also early experiences of pleasure and joy.

There is not space here to explore all of the uses and implications of the ego state model of personality structure. However, it is possible to comment on some of its features. It provides an easy-to-grasp representation of the multiplicity of human experiencing (see Rowan and Cooper 1998), and the ways in which different 'parts' of self may work together or be in conflict. It reflects one of the dominant themes in Western thought (since Freud) – the idea that the behaviour of the grown-up person is strongly influenced by what was learned or laid down in childhood. It also conveys an appreciation of the dynamic between pathology and strengths/assets in the life of a person – the Parent is both nurturing and protecting, and also critical and undermining; the Child is both hurt and avoidant, and fun-loving and curious.

## Analysis of transactions

A further domain of TA theory is concerned with describing the nature of two-person interactions, or *transactions*. Note that the concept of 'transaction' is subtly different in meaning from 'interaction': the former term implies intentionality and purposefulness on the part of each protagonist, whereas 'interaction' makes no such assumption. Transactions are represented through arrowed lines between two side-by-side ego state diagrams. A *complementary* transaction consists of an episode in which one person is communicating from one of their ego states to the corresponding ego state in the other person, who in turn is responding with a reciprocal response. Complementary transactions are not problematic – they reflect situations in which interaction proceeds in an expected and predictable manner.

There are two forms of transaction that are psychologically problematic. The first, *crossed* transactions, occur when a person emits a communication that is intended to be received by an ego state in the other person, and the other responds from a different ego state. The first person is then left 'off balance' and wondering what has happened, because they have not received the expected response. An example of this would be if Person A asks, 'What time is it?' (Adult to Adult) and Person B replies, 'Leave me alone – stop bothering me – can't you tell the time yourself?' (Critical Parent to Child). The second, *ulterior* transactions, refer to interaction sequences where the person may appear to be overtly communicating from one ego state, but in fact is sending an implicit or covert message from another ego state. An example would be:

Person A: 'What time is it?' (overt Adult message) (covert Child message: 'Is it time to make the first gin and tonic of the evening?').

If Person B responds to the overt message (by giving the time), then Person A may be annoyed and sulky, which leaves Person B feeling confused – 'What have I done? I just answered your question!' If Person B correctly interprets the implied message, and responds 'Oh, all right then, do you want ice?', then A and B could be regarded as engaging in a collusive transaction (i.e. pretence). It is easy to see how crossed and ulterior transactions can be associated with relationship difficulties – when therapy clients describe troubled relationships, TA therapists are able to use this framework to begin to make sense of what is happening, in a systematic manner.

## Games

Probably the most widely read TA book is *Games People Play* (Berne 1964); the idea of 'psychological games' has passed into everyday language usage. In relation to TA theory, Berne's ideas about games represent an attempt to make sense of aspects of human functioning and relationships that sit between the 'micro', moment-by-moment psychological states and interactions that are discussed within the theories that were developed to explain structure and transactions, and the more 'macro' level of script analysis (discussed in the following section). The theory of psychological games also makes it possible to make sense of the sometimes dramatic nature of human interactions; Berne was

working on these ideas at the same time that the great sociologist Erving Goffman was developing a broader 'dramaturgical' framework for understanding social life (Goffman 1955, 1956), and there are clear similarities between their ideas.

A game, in TA terms, can be defined as a repetitive sequence of transactions, between two or more people, that comprise a significant proportion of ulterior transactions (i.e. conducted out of Adult awareness), which incorporate a moment or moments of surprise and confusion, and which result in painful or inauthentic emotional states on the part of those who are involved. Berne (1964) suggested that each game proceeds through a set of stages. First, there is the *con* (the invitation to play the game, or opening move). This is closely followed by the *gimmick* (the 'hook' that engages the other person at an emotional level). The *response* then consists of a series of transactions, through which the main part of the game (understood as a form of time-structuring) is played out. This phase may be completed in a few minutes, or can last for years. At some point there is a *switch*, which is characterised by cessation of the ritualised series of responses, and the introduction by the initial protagonist of a dramatically different type of interaction. This leads to a moment of confusion (the *crossup*) followed by the emotional *payoff*. The payoff is understood as reinforcing the underlying life position of each protagonist (e.g. 'I'm OK, You're not OK'). Indeed, the unconscious purpose of games is that of enabling people to generate evidence for the validity of their life positions.

A simple example of a psychological game is *Why Don't You, Yes But* (Berne 1964). This game starts with Person A asking for advice: 'I am under a lot of stress at work and don't know what to do'. This request connects with the wish of Person B to be helpful and knowledgeable, so Person B begins to offer suggestions ('why don't you try to . . .'). Person B replies to each of these suggestions with the statement 'yes . . . but . . .'. Eventually, Person B runs out of suggestions, and is met by a sweet (but inauthentic) smile from Person A, and the statement 'thank you for trying to help me', uttered in a dismissive fashion. Person B feels confused – what has happened here? At this moment, each person enters an emotional state that is familiar to them. Person A feels isolated and indignant ('no one can help me; I'm not OK and other people aren't OK either'). Person B feels depressed and inadequate ('I'm no good at helping others').

The original TA thinking about games has been significantly elaborated by Karpman (1968), who suggested that games tend to be initiated by a person who adopts the role of *victim* ('please help me') and whose needs are responded to by another person who takes the role of *rescuer*. At the switch point, however, the victim becomes a *persecutor*, whereas the erstwhile rescuer is thrown into the role of victim. Karpman (1968) coined the term *drama triangle* to capture the way that each person moves around the triangle during the game.

The TA theory of games provides a powerful tool for understanding dysfunctional sequences that happen, over and over again, in the lives of people whose difficulties are enmeshed in patterns of unsatisfactory relationships with others, for example people who are addicted to alcohol, drugs, or unhealthy eating (Steiner 1979). Typically, such people are surrounded by others, such as family members, who enact complementary roles in the games that they initiate. The theory of games is a valuable analytic tool for making sense of how clients interact with each other in therapy groups and how clients and therapists interact in therapy sessions. Some TA therapists have found it useful to extend their understanding of games played between clients and therapists by drawing on psychoanalytic ideas about countertransference and enactment (Novak 2015; Stuthridge and Sills 2016). The key idea here is that, for the therapist, the experience of being drawn into the client's games allows them to gain a better appreciation of the underlying emotional difficulties and structures that the client needs to change.

## Life scripts

The various TA concepts that have been described come together at the level of *script analysis* (Steiner 1974, 1976). Berne (1975) defined a script as decisions made in early childhood, informed by observing the way in which one's parents lived their lives, that coalesced into a set of personal rules that continued to guide one's behaviour in later life in respect of how to relate to others, and the underlying

meaning and purpose of one's life. In the final book he published, *What Do You Say After You Say Hello? The Psychology of Human Destiny*, Berne (1975) suggested that a person's script was formulated in early childhood, as the young person looked around them and arrived at some basic decisions about their 'destiny'. Berne (1975) hypothesised that children need to find answers to existential questions such as 'what kind of a person am I?' and 'what happens to people like me?'

In seeking answers to these questions, children are influenced by the example set by their parents, and by the way they are treated by parents and other significant grown-up figures. However, the young person is not in a position to make rational choices, but instead needs to draw on the conceptual resources that are available to them. Berne (1975) points out that fairy tales represent a rich source of answers to the question of 'what happens to different types of people?', because fairy stories comprise a form of distilled human wisdom that has been refined and deepened through generations of storytelling. He therefore proposes that a good way to begin to make sense of the general outline of a person's life script is to ask them what was their favourite or most memorable fairy story (or, nowadays, their favourite or most memorable movie or cartoon drama). Within that story, there is likely to be a character with whom the person particularly identifies, and whose destiny has functioned as a template for the person's own life journey. For example, a woman who identifies with *Cinderella* might have spent her life as an unrecognised and oppressed princess, waiting for her prince to find her and take her away. Berne (1975) points out that people tend to remember their own personalised versions of fairy tales, in which they adapt and select key ideas and events, rather than necessarily identify with the precise detail of the tale as it is recorded in books.

In relation to the key goals of TA therapy, 'fairy tale' characters typically do not enjoy lives that are characterised by intimacy, OK-ness, and giving and receiving positive strokes. The purpose of therapy, therefore, is to enable the person to replace the fixed script that was written for them in childhood with a more flexible personal story that reflects the life decisions that the person has made for themselves.

In practice, it is no easy matter to change a life script that may have operated as a guiding life plan for many decades. The primary TA strategy, in relation to working with script, is to seek to identify and challenge the moment-by-moment psychological processes through which the script is maintained, and reproduces itself in new relationships and situations. One of the most useful ideas, in this respect, relates to the concepts of *driver* (Kahler 1978) and *racket system* (Erskine and Zalcman 1979). A 'driver' can be understood as a fundamental life principle or survival strategy that guides the person's actions in life. A driver is derived from messages received in early life from one's parents, arising from their conditional acceptance of their offspring (i.e. 'you're OK *if* . . .'). Clinical experience in TA has enabled six different drivers to be identified:

- 1 *Be strong* (you're OK if you are strong and don't feel things).
- 2 *Try hard* (you're OK if you do your best and don't have fun).
- 3 *Please me* (you're OK if you do what I say, rather than follow your own initiative or take care of your own needs).
- 4 *Hurry up* (you're not OK until you have achieved the task I have set for you).
- 5 *Be perfect* (you're OK if you always get things right).
- 6 *Take it* (you're OK if you demand what you need).

It is assumed in TA that, for each individual, the script is 'driven' by one of these statements. The task of the therapist is to help the person to recognise when they are functioning according to this pattern, and to develop alternatives that allow a wider repertoire of responses to life situations. For example, a woman living a *Cinderella* life might always be striving to *please* her potential partners, thus not allowing them to relate to her at an authentic, intimate level.

The 'racket system' refers to the strategies that a person uses in order to maintain an 'I'm not OK' position. A simple example of a racket might be if someone receives a positive and loving comment from another person, which in effect is saying to them 'You are OK'. A person who is not comfortable

with intimacy and OK-ness needs to find some means of deflecting this comment, which threatens the whole basis on which they have built their approach to life. Such a person might respond in an angry fashion: 'You don't mean it, you are just trying to make yourself look good by dishing out compliments'. A racket system is based in one or two emotions that the person has acquired as strategies for avoiding intimacy, such as feeling depressed and withdrawing from other people, getting angry and pushing people away, feeling afraid and seeing other people as threats, and so on. A racket feeling is strongly felt by the person, but experienced by others as not wholly appropriate to the situation, or exaggerated. The racket system represents a means through which the script is reinforced and maintained. For TA therapists, the aim is to enable the person to move beyond being 'specialists' in maybe one or two areas of feelings, and to be able to fulfil their potential to experience a range of feelings and emotions, appropriate to the situation that the person is in at the time.

Although script work primarily focuses on the influence of the client's mother and father, and decisions made within the family of origin, some therapists also take account of transgenerational script messages originating from the grandparents of a client, or even earlier generations (Gayol 2016). An important aspect of TA theory and practice in respect of the use of a life script perspective has been the way that script ideas have been used to make sense of the wish to commit suicide (Mountain 2000; White 2010, 2017). Suicidal behaviour is viewed as having its roots in parental messages and injunctions to 'not exist' and in early decisions around seeing suicide as the ultimate 'escape hatch' when things get tough. At the assessment stage, TA therapists aim to work with the client to identify escape hatches and negotiate their closure for the duration of therapy.

## Transactional analysis in practice

As with any approach to therapy that has existed for any length of time, TA has been interpreted and applied in somewhat different ways by various groups of practitioners. The core characteristics of any form of TA therapy have been described by Woollams and Brown (1978) as:

- using TA language and concepts, and where appropriate sharing these ideas with clients;
- working with ego states and life scripts;
- *contracting* – making an explicit agreement with the client around the goals of counselling, and keeping this contact under regular review. TA practitioners have made significant contributions to good practice in contracting (see, for example, Lee 2006; Stewart 2006);
- a *decisional* approach, which emphasises the early life decisions of the client, and their capacity to make new decisions;
- a *strengths* approach, based on an 'I'm OK, You're OK' stance: 'the therapist does not consider the client to be inadequate, defective, or incapable of modification, no matter what the diagnosis'.

Within this set of general principles, there have emerged a number of contrasting 'schools' of TA: classical, rededecision, cathexis, cognitive-behavioural, and relational. These 'schools' (and others not listed here) overlap to a large extent, but nevertheless have each developed their own distinctive brand of TA practice.

The *classical* school of TA is based on the form of practice originally developed by Eric Berne, using the group as the primary medium for therapy. The therapist allows the group process to build up, and then points out to members the games, rackets, and other 'script' behaviours that they are exhibiting. Participants in the group work together to understand these patterns, and then contract to change them.

The *rededecision* school of TA is associated with the work of Bob and Mary Goulding (1979), who have incorporated ideas and methods from gestalt therapy into their approach. They work with groups but

do not focus on group process, preferring to work with one individual at a time (the gestalt ‘hot seat’ model) with the remaining members of the group functioning as observers, witnesses, and supporters. Redecision TA therapists pay particular attention to the phenomenon of *impasse*, where the person is caught between two conflicting emotional forces or action tendencies. They also highlight the centrality of personal *responsibility* in the therapeutic process: the assumption is that the script decisions made by the person in early life can only be changed by rededitions made when they are older.

The Cathexis Institute was formed by Jacqui and Shea Schiff in the 1970s, to provide intensive, inpatient treatment for people with severe and enduring mental health problems (e.g. schizophrenia) (Schiff and Schiff 1971; Schiff et al. 1975). The distinctive feature of the *cathexis* model is that ‘craziness’ is the result of contradictory and destructive parental messages to which the person was exposed during childhood, and that the cure involves ‘reparenting’ by a therapist ‘mother’ and ‘father’, to enable the person to acquire more benign and affirming Parent functions that will allow the person to feel safe enough to use Adult and Child effectively in responding to everyday situations. This kind of work is hugely intensive, and requires a high degree of commitment and professionalism from therapists. In the early years of the Cathexis Institute, therapists even went as far as legally adopting some of their client-children. Inevitably, it proved to be difficult for some therapists to maintain appropriate therapeutic boundaries when using this approach, and there have been ethical issues associated with the application of a full-scale reparenting model. Controversial issues in the use of the cathexis approach are discussed by Jacobs (1994) and Rawson (2002). Nevertheless, many TA (and other) therapists acknowledge the value of being willing to adopt a parenting stance in relation to clients who have only known destructive and undermining attitudes and behaviour from their early caregivers (Childs-Gowell 2000). A valuable account of the contemporary use of a reparenting approach in the context of a therapeutic community is provided by Rawson (2002).

*Cognitive-behavioural* TA reflects the close affinity between TA and some aspects of CBT, specifically the use of case formulation and contracting, and attention to cognitive information-processing (i.e. Adult functioning). Cognitive-behavioural and cognitive therapy strategies can readily be integrated into a broad TA framework for understanding (Mothersole 2002).

*Relational* TA has emerged over the last 20 years, largely influenced by the writings of Helena Hargaden and Charlotte Sills (Cornell and Hargaden 2005; Hargaden and Sills 2002). They describe the origins of their approach as arising from changing patterns of clinical practice. Eric Berne and the early pioneers of TA predominantly worked with clients who were anxious, fearful, and socially inhibited. By contrast, contemporary therapists increasingly encounter clients who suffer from a sense of inner fragmentation and purposelessness, typically associated with experiences that are warded off in ‘hidden, sequestered areas of the self’ (Hargaden and Sills 2002: 3). The relational approach draws on ideas from psychodynamic psychotherapy and psychoanalysis in its emphasis on the central importance of the therapeutic relationship as an arena within which the deeply buried personal conflicts of the client (i.e. ‘sequestered areas of self’ within the Child ego state) can be identified and worked through. A distinctive contribution of relational TA has been its re-working of psychoanalytic concepts of transference, countertransference, attachment, and self within a TA framework. Compared with other schools of TA, the relational model explicitly highlights the process being experienced by the therapist (countertransference), and the use of this information as a means of exploring the relational patterns of the client.

This brief review of schools of TA practice supports a view that there is no single distinctive therapeutic intervention or method associated with this approach. Many other approaches have largely defined themselves in terms of a unique contribution to therapeutic method (for example, free association and interpretation in psychoanalysis; empathic reflection in client-centred therapy; two-chair work in gestalt therapy). Transactional analysis is not that type of therapy. Instead,



TA comprises a rich theoretical system, which can be applied in therapy using a wide range of interventions and methods.



### Case study 11.1: TA in action – the case of Martin

A good example of how an integrative model of TA therapy, drawing on various schools of practice, works in practice can be found in the case of Martin (Tudor and Widdowson 2002). The client, Martin, was a young man who was angry, socially isolated, depressed, and self-harming, who was seen for 15 sessions by a counsellor in a youth work drop-in centre. He was unemployed, had recently come out as gay and felt uncomfortable about his sexuality, and had been experiencing panic attacks in his local supermarket.

The first three sessions were devoted to gathering information, and using cognitive-behavioural relaxation exercises to enable Martin to feel grounded enough to engage in therapy. The counsellor identified that Martin was alternating between 'pleasing others' and 'being strong' drivers, and gradually began to point out these patterns, thus enabling a process of 'decontamination' of Adult ego state functioning. At the same time, the counsellor was gently operating from a Nurturing Parent position, providing Martin with information and advice designed to enhance well-being and safety. By the third session, Martin was able to collaborate in the setting of a contract that specified a number of goals for change. The counsellor suggested a number of self-soothing activities, such as taking warm baths and eating healthily, which began to establish an internalised Nurturing Parent, which in turn allowed Martin to disclose that he had been sexually abused in childhood. This new information led to a process of 'deconfusion', comprising discussion of what this event had meant for Martin at Parent, Adult, and Child levels. At each stage, the counsellor introduced Martin to more of the TA ideas behind the therapy. Over the next few sessions, Martin was able to enter a 'rededication' phase, where he looked at what he wanted to achieve in his life, and how he might realistically attain these goals.

The case of Martin is notable in demonstrating multiple ways in which TA conceptualisation can be applied in therapy through the use of a wide range of interventions drawn from other therapy traditions. In this case, the counsellor used relaxation techniques, in-vivo exposure, homework assignments, two-chair work, interpretation, letter-writing, grief rituals, as well as several other methods, while adhering to a set of basic TA principles around contracting and collaborative working.

## The organisational structure of transactional analysis

Transactional analysis is unusual among contemporary approaches to therapy in having evolved a unified international structure. All TA therapists are members of the International Transactional Analysis Association (ITAA) or one of its constituent national or regional associations, all of which are formally registered as non-profit organisations. The ITAA has developed a rigorous framework for training and accreditation, which means that all TA therapists have achieved a high standard of knowledge and competence. Unlike other therapy orientations, which have been characterised by a proliferation of splinter groups and networks, TA has remained a unified approach, which has been able to contain and build on a tradition of lively debate around theory and method. The ITAA incorporates sections that deal with educational and organisational applications of TA, in addition to counselling/psychotherapy, and publishes the *Transactional Analysis Journal*.

Although Eric Berne and other founders of TA mainly conducted therapy within groups, current TA practice is largely focused on working with individuals. Compared with other approaches, TA



counsellors and psychotherapists are more likely to be based in private practice, rather than employed in health or educational settings. There has been relatively little research into TA, which has meant that the approach has had little visibility in relation to debates around evidence-based practice and, as a result, has been marginalised by health-provision organisations such as the NHS in Britain.

## Using research to support new developments in TA therapy

The TA counselling and psychotherapy professional community has consistently sought to use research to support and evaluate the development of new ideas and interventions. Emerson et al. (1994) showed that psychological disturbance, measured using a standard symptom checklist, was associated with higher than average expression of Critical Parent and Adapted Child, and that effective therapy could reduce the predominance of these ego state functions in clients. Greene (1988) reviewed seven studies that had been carried out into the outcomes of TA therapy or training for marital problems. He found that most of the studies were of low methodological quality, and had yielded inconclusive evidence regarding the effectiveness of TA in relation to this client group. In Sweden, Ohlsson (2002) assessed the effectiveness of TA psychotherapy for clients with severe problems of drug misuse. Group TA therapy was delivered as part of a therapeutic community intervention in several centres in Sweden. Ohlsson reported that TA therapy had been highly effective with clients who had completed the course of therapy, particularly those who had received more than 80 sessions. Gains were maintained at two-year follow-up.

Novey (1999, 2002) carried out two studies in which clients who had completed TA therapy were invited to complete a retrospective questionnaire that asked them about their satisfaction with therapy, and the benefits they had experienced. The questionnaire used was adapted from the *Consumer Reports* survey conducted by Seligman (1995). Novey (1999, 2002) found that over 60 per cent of clients who had received six months or more of therapy reported major improvements in symptoms, while around 45 per cent of those who had undergone therapy of six months or less reported similar gains. The level of change found in the clients in Novey's (1999, 2002) surveys was significantly higher than in Seligman's (1995) study. However, the design of Seligman's (1995) study was more inclusive, and thus probably more likely to elicit responses from less satisfied clients. In research into the outcomes of TA therapy for clients receiving TA in a primary care clinic, van Rijn (2011; van Rijn and Wild 2013, 2016) reported effectiveness rates equivalent to other therapies. Evidence of the effectiveness of TA for trauma has been reported (Harford 2013; Harford and Widdowson 2014). Overall, findings of recent research support the conclusions of a review of research on TA by Ohlsson (2010), who argued that although some evidence exists for the effectiveness of TA counselling and psychotherapy, further studies are needed.

The most significant and distinctive research-based development within TA has been the use of systematic case-based inquiry to analyse and document the process and outcome of therapy for specific client issues: living with a long-term health condition (Julia McLeod 2013), chronic anxiety (Gentelet and Widdowson 2016), and chronic pain (Rauter 2017). A substantial international programme of TA case study research into depression has generated a large body of case-based evidence (Benelli et al. 2017a, 2017b; Widdowson 2012a, 2012b, 2012c, 2013, 2014a). This research has contributed to the development of a specific TA model of depression (Widdowson 2011, 2014b) and a treatment manual (Widdowson 2016).

An emergent area of theory and practice in TA therapy that is beginning to receive research attention is the role of spirituality from a TA perspective (Mellacqua 2016; Milnes 2017).

## Reflections on transactional analysis

The direction in which TA has been developing in recent years, particularly the movement toward psychodynamic theory and practice represented by the work of Hargaden and Sills (2002), raises

questions about the continuing distinctiveness of the approach. Is TA gradually evolving into a variant of psychodynamic counselling/psychotherapy? At present, the TA literature gives relatively little consideration to cultural factors. Although Eric Berne himself was a second-generation immigrant cultural 'outsider', and Claude Steiner grew up in Spain and Mexico, TA theory appears to pay little attention to the possibility of cultural diversity in relation to scripts, drivers, or rackets, or to the compatibility between TA ideas and indigenous forms of healing. Finally, it is surprising, given the deliberate adoption of colloquial, humorous, accessible, jargon-free language by TA theorists, that TA has not been more widely disseminated in the context of self-help books and manuals. With the exception of Claude Steiner's popular writing on emotional literacy (Steiner 1997, 2003), few TA self-help books are currently available. The production of such texts would be of assistance to TA therapy clients, as well as to the general public.

## Conclusions

Transactional analysis represents a unique resource for therapists, in providing a comprehensive theoretical system that provides both practitioners and clients with ways of making sense of how and why personal problems occur, and what can be done about them. The TA theory devised initially by Eric Berne, and which his colleagues and successors have continued to articulate, is a theory of human personality and interaction based on careful observation, classification, and categorisation, from the perspective of a theory-maker who is an outsider, interested only in what is truly happening. The point of TA is not to get lost in the intricacies of ego state diagrams or how many drivers there are. The idea, instead, is that TA represents an invitation to step aside from the 'trash which has accumulated in your head ever since you came home from the maternity ward' (Berne 1975: 4), and thereby to be able to 'see the other person, to be aware of him/her as a phenomenon, to happen to him/her, and to be ready for him/her to happen to you'. This is the radical, hopeful, and life-affirming agenda that remains at the heart of all TA therapy.



### Topics for reflection and discussion

- 1 Reflect on the meaning of the concept of 'strokes' in your own life. What is your own 'stroke economy'? To what extent are you able to give and receive negative and positive strokes? To what extent can areas of difficulty in your life be understood as associated with a tendency to 'discount' (i.e. deflect or deny) positive strokes that are directed to you by others? What are the origins, in your early life, of your current 'stroke pattern'?
- 2 Are Hargaden and Sills (2002) justified in characterising classical TA (i.e. the writings of Eric Berne) as 'essentially cognitive therapy'?
- 3 Transactional analysis theorists and practitioners place a strong emphasis on the capacity of TA theory to operate as an integrative framework, encompassing ideas from other mainstream approaches. However, how fully integrative and comprehensive is TA? When you consider the concepts and themes introduced in other chapters in this book, what are the ideas that do *not* readily fit into the TA system?
- 4 There is an obvious similarity between Freud's concepts of *superego*, *ego*, and *id*, and the Parent, Adult, and Child ego states of transactional analysis. What are the differences in emphasis between these alternative formulations? What is gained (or lost) by employing an ego state model, rather than the original psychoanalytic concepts?

## Suggested further reading

The best introductory texts on TA theory are *TA Today* (Stewart and Joines 2012) and *Into TA: A Comprehensive Textbook on Transactional Analysis* (Cornell et al. 2016). Anyone interested in understanding the spirit of TA needs to read some of Eric Berne's original writings. A good place to start is the book that he completed just before he died: *What Do You Say After You Say Hello?* (Berne 1975). The *Transactional Analysis Journal* publishes readable and practice-friendly articles that testify to the continued vitality of the TA tradition, and the willingness of the TA community to integrate and incorporate ideas from other therapeutic orientations. New development in TA theory and practice are explored in *Transactional Analysis in Contemporary Psychotherapy* (Erskine 2016).

# Chapter 12

## Gestalt therapy

<b>Introduction</b>	<b>185</b>
<b>Cultural and philosophical influences</b>	<b>185</b>
<b>Theoretical framework for practice</b>	<b>188</b>
<b>Gestalt strategies for facilitating awareness and change</b>	<b>189</b>
<b>Research into the process and outcome of gestalt therapy</b>	<b>191</b>
<b>Emerging areas of application of gestalt therapy</b>	<b>192</b>
<b>Conclusions</b>	<b>193</b>
<b>Topics for reflection and discussion</b>	<b>194</b>
<b>Suggested further reading</b>	<b>194</b>

### Introduction

Gestalt therapy is a widely used, humanistically oriented approach to therapy, developed in the 1950s by Fritz and Laura Perls, Paul Goodman, Ralph Hefferline, and others. As a form of therapy arising from the humanistic tradition, Gestalt therapy has some similarities with person-centred therapy in rejecting and yet at the same time being deeply influenced by psychoanalytic ideas, and in a shared commitment to humanistic values such as the celebration of individual freedom, creativity, and expression of feeling. The spirit of gestalt therapy was described by the British gestalt therapist Malcolm Parlett (2001) as a means for interrupting the flow of self-talk, an invitation to return to 'now', 'here', 'the actual', the 'situation' – a way of becoming more 'present', being an alive physical being who engages fully with others.

The aim of the present chapter is to provide an introduction to the ideas and methods associated with this influential approach, review its strengths and limitations, and highlight resources for further exploration and learning.

### Cultural and philosophical influences

There are several respects in which gestalt therapy is significantly different from other forms of 'talking therapy'. Organisationally and institutionally, gestalt therapy has tended to follow its own path, eschewing formal affiliation with academic departments in universities and therapy services

provided by large healthcare systems. To understand the distinctiveness of gestalt therapy theory and practice, it is necessary to have an appreciation of its cultural and philosophical roots, and the way in which it has developed.

Gestalt therapy continues to reflect the interests and values of Fritz Perls (1893–1970) who was born in Berlin. His father, a Jewish wine salesman, was financially successful, and Fritz Perls enjoyed a middle-class upbringing, albeit one in which he experienced considerable family tension. Although he was actively involved in theatre, he entered medical school. He was drafted into the German Army in the First World War, spending nine months in the trenches as a medical orderly, narrowly escaping death. He qualified as a medical doctor in 1920, and became part of the Bauhaus group of dissident artists and intellectuals.

After entering psychoanalysis in 1926, with Karen Horney, he decided to become an analyst. Within the psychoanalytic community of that era, he was particularly influenced by the ideas of Wilhelm Reich around the significance of bodily defences against authentic feeling. Fritz Perls made his living as an analyst between 1929 and 1950, first in Germany, then in South Africa (where he emigrated in 1936 as a result of the rise of fascism in Germany) and, finally, in New York. His mother and sister died in concentration camps.

Throughout his life, he openly experimented with different types of sexual experience, and was associated in the USA with ‘counter-culture’ figures such as Paul Goodman and with radical theatre groups. He found it hard, throughout his life, to maintain close relationships. Compared with Carl Rogers, and indeed with almost any other leading figure in psychotherapy, the life of Fritz Perls was characterised by alienation, first-hand experience of death and cruelty, and a personal sense of insecurity. It is hardly surprising that the therapy approach that he created placed a premium on the discovery and creation of moments of authentic contact, and paid little attention to issues of coping, or adjustment to social norms.

In the years following the death of Fritz Perls, it took some time for the worldwide network of gestalt therapy practitioners and therapists to come to terms with his legacy. He had written relatively little, and it was left to others to articulate and explain the conceptual framework of the gestalt approach. His practice reflected what could be regarded as a somewhat extreme, individualist representation of gestalt principles. As a reaction to this, a major theme in subsequent gestalt theory, training, and practice has been an emphasis on developing a more *relational* perspective. A key figure in the process of re-shaping gestalt therapy was Laura Perls (1905–1990) (Serlin 1992), who had been involved in the development of gestalt therapy from the start. Her less confrontational version of gestalt work, largely disregarded during the lifetime of her husband, became increasingly influential after his death.

Although recent gestalt writing contains little reference to psychoanalytic ideas, an appreciation of what gestalt therapy is about requires recognition of its psychoanalytic origins. Fritz and Laura Perls were both trained in psychoanalysis, underwent personal analyses, and practised as analysts for several years. Underpinning everything that happens in gestalt therapy is the notion of the ‘unconscious’: the assumption that the most important processes through which people relate to self and others are outside of conscious awareness, and that effective therapeutic work necessarily involves bringing these processes into awareness. The difference between gestalt therapy and psychoanalysis, in respect of their understanding of the unconscious, is that gestalt practitioners are primarily interested in the here-and-now expression of unconscious processes in bodily enactments, rather than in attempts to promote insight around the original causes of these processes in early childhood memories and experiences.

At the same time, it is essential to understand that psychoanalytic ideas comprise only one facet of gestalt theory and practice. Gestalt therapy also brings together important ideas from the German tradition of gestalt psychology and Lewin’s field theory. The ‘Gestalt’ school of psychology had been an influential force in the psychology of perception and cognition in the period 1930–1950 (Koffka 1935; Kohler 1929). ‘Gestalt’ is a German word that means ‘pattern’, and the key idea in this psychological model is the capacity of people to experience the world in terms

of wholes, or overall patterns, and, more specifically, to have a tendency to complete unfinished patterns. The gestalt psychologists were primarily interested in studying human perception and thought, and were responsible for familiar ideas, such as ‘mental set’ (viewing later phenomena as if they were similar to the first configuration the viewer had originally encountered) and the ‘Zeigarnik effect’ (having a better recollection of tasks that had not been completed than of tasks that had been fully finished). The ideas of the social psychologist Kurt Lewin extended gestalt psychology into the sphere of social relationships, by proposing that each individual exists within a ‘life space’ or ‘field’ that is constructed along gestalt principles. Gestalt psychology has influenced gestalt therapy in a number of ways, such as its emphasis on ‘wholeness’ and the inter-relatedness of all things, the view that the human mind actively makes meaning from whatever information is available to it, and sensitivity to the significance of boundaries, edges, and points of contact between regions of experience.

In addition to these psychological concepts, the founders of gestalt therapy were also influenced by the phenomenological tradition in philosophy, spiritual and self-enlightenment practices from Eastern religious traditions, such as Zen, the ‘body therapy’ methods of Wilhelm Reich, and an appreciation of the significance of the artistic, dramatic, and aesthetic dimensions of life. Compared with most other therapy approaches, the theoretical ‘hinterland’ of gestalt therapy is exceptionally creative and diverse. Further discussion and explanation of the underlying philosophy of gestalt therapy can be found in Brownell (2008), Wagner-Moore (2004), and Woldt and Toman (2005).



### Case study 12.1: The case of Gloria – Fritz Perls at work

One of the most famous psychotherapy cases of all time involves the ‘Gloria’ tapes (available on YouTube), where sequential therapy sessions were filmed between one client (Gloria) and three leading therapists: Carl Rogers, Albert Ellis, and Fritz Perls. The Gloria tapes have been studied by thousands of counselling and psychotherapy trainees, and have generated an ever-expanding critical and research literature (see, for example, Magai and Haviland-Jones 2002). The recording of the session with Fritz Perls provides a vivid example of the confrontational way in which the early generation of gestalt therapists worked with the here-and-now embodied experience of the client. For example, Perls regularly directed Gloria’s attention to her non-verbal behaviour through the use of statements such as:

‘What are you doing with your feet now?’

‘Are you aware of your smile?’

‘You didn’t squirm for the last minute.’

‘Are you aware that your eyes are moist?’

‘Are you aware of your facial expression?’

Immediately following the session with Perls, Gloria is reported to have said that she found these interventions to be helpful. However, some commentators have doubted whether these statements had a positive impact on Gloria within the session itself (Dolliver 1991). The now easy access to the Gloria tapes means that it is possible for anyone to examine the recordings at their leisure, and to make up their own mind. Important background information, which is not provided on the tapes themselves, included the fact that Gloria had been a gestalt therapy client for several years (not with Perls) before the recordings were made (Ellis 1991) and that, following the recordings, Gloria developed a close and enduring friendship with Carl Rogers that lasted to the end of her life.



## Theoretical framework for practice

The theoretical framework for the practice of gestalt therapy was established with the publication of *Ego, Hunger and Aggression* (Perls 1947) and *Gestalt Therapy* (Perls et al. 1951). The later writings of Perls (1969, 1973) mainly articulated the approach through examples of his work with clients, rather than through a formal theoretical presentation. Perls also demonstrated his work extensively in training workshops. An essential feature of gestalt therapy as practised by Fritz Perls was an extreme hostility to over-intellectualisation, or what he called ‘bullshit’. His approach, therefore, focused rigorously on the here-and-now experiencing or awareness of the client, with the aim of removing the blocks to authentic contact with the environment caused by old patterns (‘unfinished business’).

The emphasis on working with immediate experience, combined with Fritz Perls’ rejection of theorising, meant that gestalt therapy has often been considered to be a source of practical techniques for exploring current awareness, and enabling clients to express buried feelings, rather than as a distinctive theoretical model. There is some validity to this view, since gestalt has been responsible for a wide range of techniques and exercises, such as two-chair work, first-person language, and ways of working with art materials, dreams, and guided fantasies. Nevertheless, this approach includes a theoretical framework that contains many important ideas, and is notable for the degree to which it highlights existential issues.

It is important to acknowledge that the writings of Fritz Perls do not present a particularly balanced view of the gestalt approach as it is currently practised. Perls has been described as a ‘brilliant, dramatic, controversial and charismatic teacher’ (Parlett and Page 1990: 239) who modelled a style of working with clients that was significantly more confrontational and anti-intellectual than that adopted by subsequent gestalt practitioners. More recently, gestalt practice has moved in the direction of working with the relationship between client and therapist, development of an awareness and understanding of contact disruptions within this relationship, and less use of dramatic enactments than previously. Contemporary gestalt practitioners tend to describe themselves as employing a *dialogical* approach (Hycner and Jacobs 1995; Wheeler 1991; Yontef 1995, 1998), which has the aim of developing conversation that enables the client to become aware of ‘what they are doing and how they are doing it’ (Yontef 1995).



### Case study 12.2: The case of Rose

The case of ‘Rose’ is an account of a woman who received gestalt therapy from Bob Harman (1986) in a student counselling service over an 18-month period. Rose was severely overweight, depressed, and had difficulties in forming close relationships. This case report includes several descriptions of ways in which a gestalt therapist might try to facilitate awareness of bodily actions and feeling states within the ongoing flow of conversation. For example, right at the start of therapy, Harman paid particular attention to aspects of Rose’s non-verbal behaviour: she pushed back in her chair as far as she could go, opened her eyes as wide as possible, and held her breath. He asked her what she was experiencing at that moment. She replied that all she was aware of was that her eyes were open. However, as they continued in this vein, Rose gradually became more able to be aware of her feelings, often through moments of humour, and to trust her therapist enough to use sessions as a safe place where she could talk about what she found hard in her everyday interactions with people. Gradually, she was able to construct more of the life that she wanted to live. Reflecting on the process of his work with Rose, Harman (1986) suggested that what was most helpful was his capacity and willingness to be present with Rose, as a person.

This case report incorporates other features that may be of interest to readers, including a brief account of Harman’s own development as a therapist, and a critique of his work with Rose from several leading figures in the gestalt therapy community.

## Gestalt strategies for facilitating awareness and change

Gestalt therapists have imported ideas from drama that involved the client physically *enacting* the emotional issues in their lives. A further distinctive aspect of the approach lies in an emphasis on *conflict* between parts of the self, mirroring the personal and social conflict experienced by Perls throughout his life. Clients are encouraged to participate in experiments that allow such conflict to be brought into the open. Wagner-Moore (2004) has suggested that the rationale, within gestalt theory and practice, for the use of experiential experiments is that they allow clients to understand their own emotions and needs through a process of *discovery*, rather than through insight or interpretation. Some of the specific strategies used in gestalt practice include the following:

- The practice of gestalt therapy represents, for the client, a training in the application of the methods of phenomenology. The client is invited to report directly on their present experiencing: what is being thought, felt, and done in the here-and-now. This process creates the possibility of identifying aspects of existence ('I am alone', 'I am looking at you', 'I feel a pain in my chest') rather than merely talking or intellectualising 'about' external problems.
- The concept of *contact* is used in gestalt therapy to refer to the quality of the person's capacity to be with another person. When two people are together, there is a *contact boundary* where they meet each other. Gestalt theorists have devised a set of concepts for making sense of what is experienced at this boundary. There can be *confluence* (fusion between the two people), in which the separation and distinction between self and other becomes so unclear that the boundary is lost. In *isolation*, the boundary is experienced as impermeable – there is an absence of connectedness. *Retroflexion* represents the creation of internal boundaries by a person, who appears to be doing to self what they want to do to someone else, or doing for self what they want someone else to do for them (Yontef 1995). *Introjection* describes a process through which the thoughts, emotions, or actions of another person are absorbed or 'swallowed' whole by the person. *Projection* involves attributing to the other, emotions, thoughts, or intentions that actually belong to the self. Finally, *deflection* is the avoidance of contact or of awareness by not paying attention to the other, or by expressing things in an indirect manner. These concepts help a therapist to make sense of the experience of what it is like to *be with* a client. By engaging in conversation that invites the client to be aware of these dimensions of their existence, the client is given opportunities to make choices around autonomy/connectedness.
- A great deal of attention is paid to *embodiment*, in terms not only of how the person is feeling at any moment, but how they use their body to express meaning, through gesture, movement, voice quality, and posture.
- The notion of *polarities* within personal experience and action is a central aspect of gestalt theory and practice, as in the well-known gestalt technique of 'two-chair' work, in which the person is invited to engage in a dialogue between different aspects of self, each of which is placed on a separate chair, with the client shifting to and fro between one chair and the other as they give voice to the pattern of thinking, feeling, and action associated with each 'part' of the self.
- First-person language (for instance 'I feel . . .' rather than 'it feels . . .') is used as a means of 'owning' experience and promoting authentic self-expression.
- It involves various exercises that make use of fantasy, dream imagery, and art-making to shift the client out of their dominant rational/cognitive mode of being and into moments of spontaneous self-discovery.
- The therapist does not guide therapy through a distanced, 'objective' analysis or formulation of the client's issues and needs, but instead seeks to engage in an 'aesthetic', intuitive, and relationally attuned process of assessment and decision-making that is grounded in the present moment (Day 2016; Roubal et al. 2017).

These therapeutic activities are all part of the intention, in gestalt therapy, to assist the person to live an authentic life in which they take responsibility for their actions. It is therefore a form of

therapy that places a great deal of emphasis on the discovery of personal truth, and the elimination of all forms of self-deception.

### Box 12.1: Two-chair work

One of the therapy techniques developed by Fritz Perls and his colleagues is *two-chair* work. This method can be used when a person is stuck, or at a point of impasse, in relation to an issue in their life. From a gestalt perspective, the impasse arises because of a polarity or conflict in the self, in which one part of the self (the 'top dog') seeks to dominate and control the expression of another part (the 'bottom dog'). For example, a person may feel angry about something that is happening in their life, but the expression of this anger is suppressed by a belief that anger is bad and destructive. As a result of this impasse, the person withdraws from contact with the external environment and other people – the emotion that should really be directed outwards is held within.

In two-chair work, the therapist invites the client to sit in one chair and 'be the anger', and then move to an adjacent chair and 'be' the controlling self and reply to what 'anger' has said. The client then moves back into the first chair, and responds again from 'anger'. Throughout this activity, the therapist coaches the client to remain within each role, and to speak directly from that position. Typically, this dialogue leads to increasing emotional tension, and an eventual melting or dissolving of the impasse, as each part comes to accept the right of the other to exist, and arrives at a creative solution that satisfies each of them ('it is OK to be angry as long as you take care of yourself').

The origins of this technique in the lifelong interest that Perls had in theatrical performance are easy to see – during two-chair dialogue, the therapist almost becomes a drama coach or director. Two-chair work (and variants of it) has been the focus of research by emotion-focused therapist Les Greenberg and his colleagues and this technique forms a central part of the EFT approach. The EFT literature contains a valuable analysis of the situations in which two-chair work is most appropriate, and the sequence of therapist and client actions that are associated with its effective deployment (Elliott et al. 2003; Greenberg 2002). However, emotion-focused therapy does not incorporate the underlying theory of personality associated with gestalt therapy. A broader, theoretically integrative perspective on two-chair work has been developed by Kellogg (2004, 2014).



### Case study 12.3: The case of Irvina

A good example of contemporary gestalt therapy practice can be found in a case study written by Fabienne Kuenzli, an experienced gestalt therapist who worked in the USA. The case describes the process of therapy during the first four sessions of her work with Irvina, an 18-year-old Mexican-American woman who had been in care and been adopted, and had previously received multiple episodes of therapy over several years. Over the course of her life, Irvina had experienced emotional rejection and sexual abuse, and at the time of entering gestalt therapy had major difficulties around controlling her anger, and was suicidal.

The case report constructed by Kuenzli (2009) provides several examples of what a gestalt therapist does to facilitate dialogue with a client. Several of these examples refer to episodes

in therapy where the therapist was highly sensitive to the language of the client, for instance around use of psychiatric labels. She did her best to follow the client's word use – including one instance in which the therapist used swear words. Another episode of dialogue occurred when the client arrived for a session wearing sunglasses with blue lenses – the therapist asked if she could try them on, to experience what it was like to be in a 'blue' world. On a further occasion, when Irvina complained of feeling tired, the therapist invited her to lie down on a couch and close her eyes.

This case study is particularly notable in the extent to which it describes the awareness, reflexivity, and inner dialogue of the therapist herself. It is very clear that the dialogical contact with Irvina was made possible by a highly tuned self-awareness on the part of her therapist. This contact seemed to make it possible for Irvina to begin to make important changes in her life – get close to a boyfriend who was not sexually exploitative, get a job, write poetry. The case clearly illustrates the extent to which current gestalt therapy has moved away from the staging of dramatic therapeutic events or change moments, towards an application of gestalt principles that are expressed in conversation, spontaneous moments of creativity, and a caring relationship.

## Research into the process and outcome of gestalt therapy

One of the distinctive aspects of the gestalt therapy literature, in contrast to those of other leading therapy approaches, is that it is characterised by a much more limited research tradition. The lack of research into gestalt therapy is an interesting phenomenon in its own right, because it is clear that gestalt theory and practice have continued to grow and develop over the past 30 years, even without a recognisable research base. It is not entirely clear why the gestalt therapy community has chosen to keep conventional empirical research at a distance. Gold and Zahm (2008) suggest that the reasons why gestalt therapy is not well researched include:

- a reaction to what is regarded as the 'over-intellectualised' theory and practice of psychoanalysis;
- the radical, anti-establishment views of the founders of gestalt therapy;
- it is obvious to those who practise it that it is effective.

Other gestalt therapy writers have argued that gestalt therapy represents a creative flexible approach to working with people – any attempt to standardise it for research purposes would therefore destroy what it sets out to investigate. Finally, there is also a view that evaluating change in terms of symptom reduction misses the point of what gestalt therapy seeks to achieve.

The situation in respect of research into gestalt therapy is in fact quite complex. Two of the leading figures in contemporary psychotherapy research, Larry Beutler and Les Greenberg, have published a considerable number of high-quality studies into specific gestalt interventions. Much of Beutler's work, over several decades, centred on the question of whether certain therapeutic approaches are more effective for clients with different coping styles. For example, in one study, Beutler et al. (1991) looked at whether the effectiveness of three contrasting therapies (CBT, supportive therapy, or experiential therapy that included some gestalt interventions) depended on the ways that depressed clients dealt with their emotions, and the way that they related to their therapist. What he found was that the experiential/gestalt therapy was fairly effective for clients with all coping styles.

Greenberg and his colleagues have carried out several studies (see Greenberg 2008) that have examined the effectiveness of specific gestalt interventions, such as two-chair work, and have sought to identify the step-by-step sequence of activities that is associated with more impactful and less impactful deployment of these techniques. They have also carried out controlled studies that have evaluated the effectiveness of emotion-focused therapy (an integrative form of therapy that embraces ideas and methods from person-centred and gestalt approaches). They found that EFT was at least

as effective as other leading forms of therapy, such as CBT, for conditions such as depression, and that two-chair work and other gestalt interventions are potent therapeutic interventions in their own right. A more detailed account of emotion-focused therapy can be found in Chapter 10.

Although the work of Beutler, Greenberg, and their colleagues certainly provides support for the effectiveness of particular elements of gestalt therapy, it is not possible to conclude, on the basis of this evidence, that gestalt therapy as it is routinely practised produces beneficial outcomes. Leading figures within the gestalt therapy community, such as Yontef (1993), have consistently argued that gestalt therapy cannot be reduced to techniques and interventions, and that anything other than the whole philosophical 'package' cannot be considered as representing the reality of gestalt therapy in action. From this perspective, the studies carried out by Beutler and Greenberg cannot be considered evidence of the benefits of gestalt therapy.

Research into the effectiveness and outcomes of gestalt therapy has been summarised and reviewed by Stevens and Wakelin (2016), Strümpfel (2004), and Strümpfel and Goldman (2001). Although these reviews identified a large number of studies, many of them used methodologies that are idiosyncratic, or investigated the impact of gestalt therapy experiences for people seeking personal growth rather than those struggling with emotional difficulties. There is limited evidence, from this body of literature, of the effectiveness (or otherwise) of gestalt therapy for the kinds of clients who attend most counselling/psychotherapy centres and services. This does not mean that gestalt therapy lacks effectiveness – it just means that relevant evidence has not been collected. An important initiative to align gestalt therapy outcome research more closely to the mainstream research tradition has been inaugurated by Stevens and Wakelin (2016).

Some individuals within the gestalt therapy world network have pursued an alternative strategy in relation to what they regard as the philosophical limitations of conventional therapy research. Rather than employ established outcome and process measures, or qualitative analysis of interviews, these groups have sought to create a new approach to research that is consistent with the values and ideas of the gestalt tradition. An example of this kind of effort can be found in the work of Scheinberg and colleagues (2008), who draw on gestalt ideas such as the importance of dialogue, and the cycle of experience, to guide their research programme.

Recently, there has been a movement in the direction of defining a broad agenda for research in gestalt therapy, based on a range of established methodologies (Roubal 2016). One strand of this research that has received particular attention is the use of rigorous single case analysis (Herrera et al. 2018a; Wong et al. 2016), an approach that has been used to analyse the process and outcome of gestalt therapy in cases of substance misuse (Aiach Dominitz 2017) and anxiety (Herrera et al 2018b). Other studies have used qualitative methodologies to explore the process of change in gestalt therapy (Roubal and Rihacek 2016; Sandell 2016).

## Emerging areas of application of gestalt therapy

Gestalt therapy can be applied in individual, couple, and group therapy, and there are examples in the literature of gestalt work with clients with presenting problems from across the entire diagnostic spectrum. There is also a growing area of application in the field of organisational development (Barber 2012). Given the substantial interest, in many countries, in finding effective ways to address emotional and behavioural problems in children and young people, one of the most significant emerging areas of development in gestalt therapy may turn out to be Violet Oaklander's model for working with young people (Mortola 2014). This is an approach that combines art techniques with a gestalt emphasis on facilitating the client's authentic contact with the world. Another area of contemporary practice where gestalt therapy has the potential to make a major contribution is around the use of therapy to promote social justice (see Chapter 26). Examples of the use of gestalt therapy ideas and techniques to empower individuals and communities to engage in political change and transformation can be found in González-Hidalgo (2017) and Melnick and Nevis (2012).



## Box 12.2: Can gestalt therapy be combined with other therapeutic approaches?

The position of gestalt therapy in relation to therapy integration appears to be somewhat one-sided. On the whole, leading figures within the gestalt therapy community seem to have shown little interest in assimilating concepts and practices from other approaches. On the other hand, for several decades the gestalt tradition has provided rich picking for practitioners from other approaches (see Thoma and Cecero 2009). Gestalt methods of active experimentation, creative dream work, first-person language, two-chair work, and much else, have been incorporated into the repertoires of many therapists. There are several points of convergence between person-centred/client-centred and gestalt approaches (see Greenberg et al. 1998). An influential and widely read book by James and Jongeward (1971) harnessed gestalt techniques as a means of applying transactional analysis theory. Amendt-Lyon (2001) has discussed the connections between art therapy and gestalt therapy, and Tonnesvang et al. (2010) has explored links with cognitive therapy.

## Conclusions

Gestalt therapy has a great deal to offer to anyone in a therapy role or who is seeking therapeutic help. Historically, there has been a tendency within the world of counselling and psychotherapy to view gestalt therapy as a repository of powerful change techniques: two-chair work, gestalt dreamwork, body awareness exercises, first-person language, and so on. However, this kind of appropriation of gestalt techniques is missing the point. Close attention to what gestalt therapists actually do in practice suggests that what is truly distinctive about this approach to therapy is a capacity to apply an intensely focused awareness of what is happening in the present moment. Rather than using the interaction with a client to collect information that can be used to arrive at a formulation of whether the client has negative automatic thoughts, or an external locus of evaluation (or whatever), gestalt therapists try to develop a sense of the quality of interpersonal contact that exists at that moment, and in particular what the client does to make contact, avoid contact, and keep safe. It is only possible to engage in this kind of work, as a therapist, on the basis of extensive training and practice. It is, perhaps, like walking a tightrope. Most people can do it for a moment or two, but then fall off because they start to think about other things, or get scared. To be able to stay on the tightrope requires a capacity to be still inside and to be responsive to tiny movements.

The gestalt therapy community has needed to develop a philosophical framework from which the present moment can be understood. The key element of this framework is phenomenology, which is built around the idea that truth can be found through staying with an experience to a sufficient extent that something of the essence of that experience or phenomenon can be disclosed. A willingness to follow the logic of phenomenology then leads in a number of directions that have become central to gestalt theory and practice.

Phenomenological philosophers such as Maurice Merleau-Ponty have demonstrated that the experience of embodiment, and the reality of one's own body and the bodily presentation of other people, is a central aspect of the 'essence' of personal experience. Other phenomenological philosophers have shown that experience always occurs in a 'field' or contact – there is always a sense of some kind of 'being-with'. Finally, the phenomenology exploration of the use of language shows that talk is always dialogical, in the sense of being directed at or in response to a real or imagined 'other'. In these respects, it can be seen that gestalt therapy theory and practice is consistent with important developments in twentieth-century philosophy.





## Topics for reflection and discussion

- 1 One of the characteristic strategies of gestalt therapy is to invite the client to be aware of, and report on, what they are doing *now* – the moment-by-moment flow of their thoughts, feelings, and actions. What might be the advantages and disadvantages of this therapeutic strategy?
- 2 As a client, what are the elements of gestalt theory and practice that seem potentially helpful and relevant in relation to the issues that you struggle with in your own life? In what ways might your life be enhanced by these new ideas?
- 3 Who are the groups of clients or what are the types of problem for which gestalt therapy might be most effective? What are the areas in which it might be least effective?
- 4 To what extent, and in what ways, does gestalt therapy reflect the ideas and values of Western culture?

## Suggested further reading

The classic texts that defined the direction of travel of post-Perlsian gestalt therapy are *The Healing Relationship in Gestalt Therapy* by Hycner and Jacobs (1995) and *Awareness, Dialogue and Process* by Gary Yontef (1993). The best sources of information around current developments in this approach are Ginger (2007), Joyce and Sills (2018), Mann (2010), and Wheeler and Axelsson (2015). An introductory text that explicitly seeks to take gestalt therapy back to its origins in gestalt psychology is that of Wollants (2012). An edited collection of papers that represent new ways of thinking within the gestalt tradition is *Gestalt Therapy in Clinical Practice: From Psychopathology to the Aesthetics of Contact* (Francesetti et al. 2013).

# Chapter 13

## Existential therapy

<b>Introduction</b>	<b>195</b>
<b>Existential themes</b>	<b>196</b>
Being alone/being with others: isolation, autonomy, and relatedness	196
Death/living in time	197
Agency/freedom	198
Identity/embodiment	198
Meaning, truth, and authenticity	199
<b>Existential therapy</b>	<b>199</b>
Basic principles of existential therapy	200
Existential therapy techniques	202
<b>Existential therapy in action</b>	<b>204</b>
Existential therapy for sexual difficulties	205
Existential therapy for long-term schizophrenia	205
<b>Conclusions</b>	<b>206</b>
<b>Topics for reflection and discussion</b>	<b>207</b>
<b>Suggested further reading</b>	<b>207</b>

### Introduction

Therapy offers the person a space, outside the busy flow of everyday life, within which they can reflect on how things are going, and in particular engage in exploration around things that are going wrong, in the hope of resolving such problems in living. Much of the time, the reflective space provided by therapy is used to address practical problems: 'How can I have a more satisfying relationship with my partner?' 'How can I be less anxious, and more confident when asked to give my opinion at a staff meeting?' 'How can I reconstruct my life now that my mother has died?' At the same time, however, the opportunity for reflection that arises in therapy can often lead clients in the direction of thinking about the deeper issues that underpin their practical dilemmas: Not 'how to communicate better with my partner' but 'what does *love* mean to me?' Not 'how do I learn relaxation skills' but 'what is the *purpose* of my work?' Not 'what do I need to do to grieve and move on?'

but ‘what does *death* mean for me?’ These underlying questions, about the basic meaning of central aspects of life, are *existential* in nature – they are questions about the quality of existence, the fundamental sense that I might have of *being* human. It is perhaps quite seldom that a therapy client will define their primary goal for therapy as that of exploring issues of existence and being. On the other hand, it is common for any client who attends more than a couple of therapy sessions to encounter existential issues in some shape or form.

Sensitivity to questions of being and existence is an essential therapist competence; an absence of awareness of core existential issues runs the risk of the therapy conversation becoming superficial. The aim of this chapter is to examine the significance of an existential perspective in counselling and psychotherapy theory and practice. The chapter begins by briefly outlining key existential themes, then moves to an overview of the theory and practice of existential therapy.

## Existential themes

The understanding and analysis of existential themes, within Western culture, owes a great deal to the work of existential philosophers such as Martin Heidegger (1889–1976), Søren Kierkegaard (1813–1855), and Jean-Paul Sartre (1905–1980). These writers lived within a European culture, in the late nineteenth and early twentieth centuries, in which previous sources of meaning, largely derived from collection traditions organised around religion, family, community, and place, were being eroded and undermined by the progress of modernity. As a result, they and others were faced with a stark question: what does life mean? In exploring their question, they employed the philosophical method of *phenomenology*, which involves setting aside, as much as possible, any pre-existing assumptions that one holds in relation to an area of experience, and through this strategy gradually arriving at a disclosure of the *essence* – or essential qualities – of that experience. So, for example, a phenomenological inquiry into the experience of marital conflict might reveal a set of component meanings around essential qualities such as love, commitment, and responsibility.

Phenomenological inquiry is far from being an exact science: an understanding of the meaning of any particular aspect is never complete. Instead, what phenomenology offers is a way of moving from a position of taking things for granted, to a position of openness, curiosity, and discovery. The challenges of, and background to, phenomenological-existential inquiry is explored in Moran (2000) and Moran and Mooney (2002). What has emerged over the course of time, in the work of phenomenological philosophers, has been the identification of some key existential themes that run through human existence: isolation/being with others, death/living in time, agency/freedom, identity/embodyment, and truth/meaning (Koole et al. 2006; Wartenberg 2008). These themes are explored in the following sections.

### Being alone/being with others: isolation, autonomy, and relatedness

Social being constitutes an irreducible aspect of human existence: we live our lives both in connection with others, and alone within our own private awareness. There are two basic questions, for each of us, that arise from this aspect of existence: What is the quality of my contact and connectedness with others? What is the quality of my experience of being with ‘me’, of being alone?

The modern world opens up staggering possibilities for individual autonomy. In traditional cultures, people depended on each other, for food, shelter, and security, in very tangible and obvious ways. For the majority of people, there were very limited choices, even in relation to what they ate or where they lived. All this seems to be different in the modern world. We are individuals. We please ourselves. We have rights. We consume. As many people have observed, the growth of individualism has gone hand in hand with the growth of counselling and psychotherapy. As individual selves, we might seek to deal with our anxiety, fear, depression, and destiny on an individual basis, in the

privacy of a confidential therapy room. Individualism is built into the fabric of society in such forms as the design of houses and cars, the organisation of the tax system, the plotlines of novels, films, and plays. Yet, in the end, the individualism of the modern world is false. We are all profoundly interdependent, at both personal and economic levels. Anxiety, depression, and destiny are embedded in relationships with others, are understood through shared cultural conceptions, are assuaged through talking to someone who accepts and understands.

The most important relationships a person has are (usually) when they are a child and being a parent, and the most important group to which a person belongs is their family. In therapy, people talk about how they feel about these relationships, and try to find the best mix of giving and taking, caring and being cared for. Likewise, the existential issue of autonomy underpins conversations about how a person spends their time, how they make decisions and choices, and the extent to which they accept who they are or perhaps wish to destroy a 'self' that cannot be tolerated.

To be a person in modern society is therefore to be caught in a field of great tension, simultaneously pulled in the direction of individual autonomy and alone-ness, and in the direction of connectedness, relatedness, and the communal. All approaches to therapy, and all therapists, have had to find their own way of addressing this question, of resolving this tension. Many approaches have attempted to deal with it by excluding or redefining the social. In person-centred theory, the social becomes a set of generalised 'conditions of worth'. In psychodynamic theory, the social is dealt with in terms of attachments and 'internalised objects'. By contrast, systemic and family-oriented approaches downplay the individual and highlight the communal. Other approaches, such as multicultural and feminist therapies, strive to find ways of incorporating both the social and the individual within their models of the person. What all approaches share is the necessity of coming up with some means of talking about the tension between the individual and the collective, some way of carrying out a conversation – however stilted or partial – around this pervasive existential theme.

## Death/living in time

As persons, we live in time. Our plans and aspirations stretch out into, and create, a future. The past is represented not only in our memories, our mental images, and recollections, but through the meanings that external objects and places hold for us. One of the basic human dilemmas arises from the task of being able to locate oneself in time and history. There seems to be a basic human tendency or need to construct a story of one's life, with a beginning, middle, and end (or possible endings). Many of the problems that people bring to therapy can be seen as distortions of the person's relationship with time: depression is a time with no hoped-for future state, compulsive behaviour is warding off a feared future event, low self-esteem may entail returning again and again to a moment of failure in the past.

Although the different approaches to therapy must each be flexible enough to enable the client to move across past, present, and future, each model has its own distinctive time slot. Humanistic approaches emphasise 'here-and-now' experiencing. Behavioural approaches are more concerned with what will happen in the future: achieving behavioural *targets*; relapse *prevention*. On the whole, most therapy models operate within the time frame of the client's personal life. However, some family therapy approaches stretch this personal time frame to encompass intergenerational influences. The more culturally oriented therapies, such as the feminist, multicultural, and narrative approaches, operate within an extended time frame that may include events well outside the family history of the individual client. For example, some multicultural therapists would see relevance for some clients in developing an awareness of the history of racism. In all of these approaches, therapy can be seen as a means of assisting people to construct an identity that is positioned in time and history.

A further crucial aspect of the experience of time, as a basic dimension of existence, arises from the question: 'When does time end?' The end of time, for each of us, is death. Although there are many meanings that death can have, for individuals and cultural groups, it remains a basic given of human experience. Contemporary industrial-scientific cultures have tended to seek to deny the

reality of death, by truncating traditional death rituals and creating a detached viewpoint on death in the form of movie and television dramas in which death occurs somehow painlessly and without personal meaning. And yet it hardly needs to be said that the relationship that a person has with their inevitable death, and with the deaths of others, has a profound influence on the way in which that person lives their life.

## Agency/freedom

What does it mean to *intend* something, to act with intentionality and purpose? What does it mean to be *powerful*, to be able to exert influence and control? What does it mean to be *powerless*, to be a victim of oppression, to be controlled by others? What is the right balance in a life between powerfulness and powerlessness, between controlling others and allowing them to control oneself, domination and submission? As human beings, we possess many powers, and are confronted by the power of others. These aspects of experience can be regarded as arising from the core human experience of *agency*. There is an inevitability in any life to the experiencing of triumph, joy and achievement (the personal expression of agency), pain and suffering (being subjected to the malign agency of others), caring and nurturance (being subjected to the benign agency of others).

Within society, power differences are structured and institutionalised around fundamental demographic categories, such as class, race, and gender. Dilemmas and issues around the nature of power, control, and agency are intrinsic to therapy, for both therapist and client. Does the therapist adopt a position of expert (i.e. the powerful one who 'intervenes'), or the stance of being a client-centred equal or of 'not-knowing' witness? How much does the therapist say in the therapy room? *What* kinds of statement do they make – reflection, instruction, interpretation? Is the aim of therapy self-control and self-management, or a self-fulfilment that reflects a celebration of personal power? How is the person who has been oppressed, as in childhood sexual abuse, encouraged to name their experience? Are they 'victims', 'survivors', or 'post-traumatic stress disorder sufferers'? Should this person seek to express their power through anger or through forgiveness? How much responsibility does a person have, in respect of their actions and life difficulties? These are just some of the many examples of issues of human agency and choice that are implicit in therapy.

## Identity/embodiment

To be a person is to be embodied, to have physical presence and sensations, to move. Living with, and within, a body presents a continual set of challenges. The person's relationship with their body is one of the central issues in many (perhaps all) therapeutic contexts. The primary area in which aspects of the body become apparent in therapy is through the existence (or non-existence) of feeling and emotion. We feel in our bodies, and these feelings or emotions are indicators of what is most important to us. Our bodies tell us how we feel about things. And we live in a culture in which acknowledging, naming, and expressing emotions is deeply problematic. Mass modern society places great value on rationality, self-control, and 'cool'. For many people, the therapy room is the only place in which they have permission to allow themselves fully to feel. All approaches to therapy, in their very different ways, give emotion a high place on the therapeutic agenda. Another crucial dimension of bodily experiencing is sexuality. The person's relationship with themselves as a sexual being, as someone with sexual powers and energies, can often be a core issue in therapy.

Other identity issues that centre on the body are concerns about eating, digesting, defecating, being big or small, being attractive or ugly. Finally, there are many highly meaningful experiences that people have around health, including fertility, being ill, dealing with loss of functioning or parts of the body, and the encounter with death. The common thread through all these identity issues is the experience of embodiment. We are all faced with the issue of what our body means to us, and how we accept or deny different aspects of our bodily functioning. Counselling is a setting in which some of these issues can be explored and reconciled, and all counsellors and theories of counselling adopt their own particular stance in relation to the body.

## Meaning, truth, and authenticity

How do we *know*? What counts as valid knowledge? What is the *right* thing to do? People act on the basis of what they believe to be true, and so the issue of what is to count as true knowledge is therefore a fundamental question with profound implications. However, knowing what is true and what is right is far from easy for members of modern technological societies. First, there are many competing sources of authoritative knowledge. In the past, most people would have accepted the teachings of their religious leader or text as the primary source of true knowledge. Now, the majority of people doubt the validity of religious knowledge, and look instead to science to provide certainty and a reliable guide to action. On the other hand, scientific knowledge can be questioned in terms of the areas of human experience which it excludes. There is a reawakening in some quarters of the value of spiritual experience as a source of knowledge. Other people look to art as a source of knowledge, claiming that insight and understanding are developed through the use of creative imagination and different modes of representing reality. Finally, through all this, many people maintain a belief in the truth of their own everyday common-sense experience.

Therapy reflects this multiplicity of knowledge sources; different approaches to therapy can be viewed as encouraging clients to specialise in one or another mode of knowing. For example, cognitive-behavioural therapies place great weight on objective, scientific knowing, psychodynamic and person-centred approaches emphasise the validity of personal feelings and memories, whereas transpersonal therapies attempt to create the conditions for spiritual learning. A central theme, in much therapy, concerns the quest of the individual for their own personal truth – for a sense of authenticity, genuineness, and ‘realness’, in contrast to a sense of being ‘false’ or a ‘fraud’. This theme reflects a search for an answer to questions such as, ‘What is the truth about *me*?’ ‘Who am *I*?’

The core existential issues discussed earlier – being with others, agency/power, time, embodiment, and truth – are inevitably interlinked in practice. These issues represent some of the basic questions or dilemmas that we face as members of the society in which we live; therapy is one of the few arenas in which we are allowed an opportunity to reflect on how we deal with them. All therapy theories provide frameworks that enable people to engage, to a greater or lesser extent, in a personal conversation about these issues.

### Box 13.1: Measuring existential concerns

There have been many attempts to develop questionnaire measures of existential themes, as a means of evaluating the prevalence of such issues in the population as a whole, and the degree to which such factors are impacted by the experience of therapy. Such measures also serve a valuable function in offering a concrete, down-to-earth definition of concepts that may otherwise be perceived as over-abstract. One of the most recent scales to be produced is the Existential Concerns Questionnaire (ECQ; van Bruggen et al. 2017). Among the dimensions assessed by this measure are: general existential anxiety (‘I worry about not being at home in the world, as if I do not belong here’, ‘the awareness that other people will never know me at the deepest level frightens me’); death anxiety (‘it frightens me that at some point in time I will be dead’, ‘it makes me anxious that my life is passing by’); and avoidance of existential concerns (‘I try to avoid the question of who I really am’).

## Existential therapy

Existential therapy is a form of therapy in which the problems presented by the client are conceptualised in terms of the existential themes introduced in the previous sections of this chapter. It



is possible to identify several distinct traditions or schools of existential therapy (Correia et al. 2014, 2017, 2018). One important strand has evolved from the work of European psychoanalytically oriented therapists such as Boss (1957) and Binswanger (1963). This body of work influenced the work of the Scottish psychiatrist and psychotherapist R. D. Laing (1960, 1961). Another significant strand consists of American existential-humanistic therapists such as May (1950), Bugental (1976), and Yalom (1980). The work of Viktor Frankl, a European psychotherapist who lived for many years in the USA, is also a valuable resource for counsellors interested in an existential approach. Although the model of therapy developed by Frankl is described as 'logotherapy', it is in fact existentially informed. The writings of Emmy van Deurzen, Ernesto Spinelli, and Mick Cooper comprise important contributions to a British tradition of existential psychotherapy and counselling. The Society for Existential Analysis functions as a vehicle for current developments within this latter approach, and operates a journal. There are also many therapists who incorporate existential ideas in their work with clients, without explicitly describing themselves as being existential therapists. For example, therapists who focus on issues of meaning in life (Hill 2018) are likely to draw on existential insights.

May et al. (1958) remains a core seminal text in existential psychotherapy, and offers a thorough grounding in the European roots of this approach. This book is, however, a difficult read: more accessible introductions to the principles and practice of existential therapy can be found in Bugental (1976), Cooper (2012, 2017), van Deurzen (1988), and Yalom (1980). The growth of interest in existential ideas within British counselling and psychotherapy is reflected in books by Cohn (1997), Cohn and Du Plock (1995), van Deurzen (1996), Strasser and Strasser (1997), Du Plock (1997b), and Spinelli (1997), and chapters by van Deurzen (1990, 1999) and Spinelli (1996). A useful introduction to the broader field of existential-phenomenological psychology, which provides an underlying framework for existential therapy, is Schneider and May (1995).

## Basic principles of existential therapy

Within the broad tradition of existential therapy, there have been several different interpretations of how existential concepts can best be translated into therapeutic practice. Cooper (2017) argues that an underlying theme in existential therapy is a concern to explore the meaning of 'human lived-existence' and the experience of 'being-in-the-world'. In the discussion that follows, no attempt has been made to differentiate between different styles of existential therapy. Instead, the aim is to identify a common core of existential ideas and methods that can offer a starting point for anyone interested in this form of practice.

The goals of existential therapy have been described by van Deurzen (1990) in the following terms:

- to enable people to become truthful with themselves again;
- to widen their perspective on themselves and the world around them;
- to find clarity on how to proceed into the future while taking lessons from the past and creating something valuable to live for in the present.

These goals encapsulate a vision of the possibilities of therapy as a means of enabling a person to live in ways that are more authentic and truthful, open to new experience, and able to take action. These distinctive therapeutic goals are similar to the goals of psychodynamic (insight), humanistic (self-acceptance), and CBT (behaviour change) approaches but seen from an existential perspective offer a more philosophically informed understanding of human experience.

In order to help clients to accomplish these goals, the practice of existential therapy is based on three key principles: a genuine relationship between client and therapist, the capacity of the therapist to make sense of life from an existential perspective, and the application of a phenomenological approach to inquiry and knowing.

*A genuine relationship between client and therapist.* If the client is to be assisted to live their life in an authentic and honest way, the best place to start is in the therapy room. Existential therapists

are profoundly influenced by the ideas of the philosopher Martin Buber concerning the difference between an 'I-thou' and an 'I-it' relationship. An 'I-thou' relationship reflects a willingness to view the other as a living, aware person with reasons and choices. By contrast, an 'I-it' relationship reduces the other to the status of an object. An existential understanding of the meaning of genuine, authentic relating (as opposed to false relating based on pretence and manipulation) draws on the work not only of Buber, but philosophers such as Sartre, Macmurray, and Levinas. The type of therapy relationship offered by existential therapists is characterised by genuine, caring, respectful involvement in the life of the client. Existential therapists pay attention to the quality and characteristics of their way of being with the client, and the client's way of being with them.

*The capacity of the therapist to make sense of life from an existential perspective.* Training in existential therapy involves studying the work of existential philosophers, and learning how to apply their ideas in one's own life. This is a time-consuming and demanding process, because one of the key aspects of an existential perspective is that it seeks to disrupt ordinary, taken-for-granted ways of thinking in order to make it possible to experience reality and being as they really are. The writing of existential philosophers such as Heidegger, Sartre, and Merleau-Ponty is often difficult to follow, because, in trying to reach beyond the ways in which we ordinarily speak of things, they frequently find it necessary to invent new terminology. A practical, lived understanding of existential thought has the effect of sensitising the therapist to the lived quality of existence of their clients. For example, anxiety is an issue, in some shape or form, for most clients. For existential philosophers, anxiety is not a symptom or sign of psychiatric disorder, but instead is regarded as an inevitable consequence of caring about others, and the world in general. From this perspective, it is a lack of anxiety (revealed as a sense of inner emptiness or alienation) that would be viewed as problematic. An exploration of the meaning and experience of anxiety opens up other existential dimensions of life. Existential philosophy suggests that to be a person is to be alone and at the same time to be always in relation to other people. Understanding the quality of a person's existential contact with the *other* is therefore of great interest to existentialists: is the person capable of being both alone and in communion with others? From an existential point of view, authentic being-in-the-world requires an ability to take responsibility for one's own actions, but also a willingness to accept that one is 'thrown' into a world that is 'given'. Much of the focus of existential analysis is on the 'way of being' of a person, the qualitative texture of their relationship with self (*Eigenwelt*), others (*Mitwelt*), and the physical world (*Umwelt*). An existential therapist who has learned to see the world in these terms is therefore able to view anxiety not only as a symptom or problem or set of behaviours and cognitions (all of which may be part of the experience of anxiety for a client), but as a profoundly meaningful phenomenon. As the client begins to understand, more fully, what their anxiety means to them, they become more able to live in ways that are satisfying, creative, and productive, because this understanding gives them options and choices.

*The application of a phenomenological approach to inquiry and knowing.* In order to explore and develop an understanding of being-in-the-world, existentialists use the method of phenomenological reduction, initially devised by Edmund Husserl. This is based on a process of 'bracketing-off' taken-for-granted assumptions about experience, in an attempt to arrive closer to the 'essence' or truth of that reality. The aim is to uncover the basic dimensions of meaning or 'being' that underpin everyday life, and by doing so be better able to live an authentic life. Spinelli (1989, 1994) has described this method, as applied in therapy, as comprising three basic 'rules' for therapists:

- 1 The rule of *bracketing*, or putting aside (as best we can) our own assumptions in order to clear our perceptions and actually hear what the other person is expressing.
- 2 The rule of *description* – it is important to *describe* what you have heard (or observed) rather than rushing into theoretical explanation.
- 3 The rule of *horizontalisation* – the therapist seeks not to be judgemental, but to try to hear *everything* before allowing importance to be attributed to any part of the experience.

A detailed account of how this works in practice can be found in van Deurzen (2015).

The use of phenomenological inquiry in therapy has a number of therapeutic effects. It reinforces a collaborative and equal relationship between client and therapist – they need to work together to carry out the steps of bracketing, description, and horizontalisation. The therapist is not trying to impose their ideas on the client, but is open and curious about what things mean for the client, from the client's perspective. This not only strengthens the client–therapist relationship, but may also allow the client to learn about a potentially valuable way of relating to other people in their life. Furthermore, once the process of phenomenological inquiry gets underway, it yields new material, or discoveries for the client, while at the same time allowing the client to see how different aspects of an issue fit together. Finally, once the client gets the hang of phenomenology, they can use it on their own, such as when they get stuck or are finding it hard to cope.

### Box 13.2: Phenomenological research

Phenomenological philosophy addresses the fundamental givens of human existence, such as choice and isolation. By contrast, empirical phenomenological research explores the experience of specific aspects of experience in particular situations. This kind of research, which makes use of methods of phenomenological inquiry to explore aspects of lived experience, represents an important resource for existential therapists. For example, studies carried out by the group led by Steen Halling at Seattle University, into topics such as despair (Beck et al. 2005) and forgiveness (Halling et al. 2006a), offer therapists sensitive and carefully described insights into the nature of issues that are highly relevant in therapy. Phenomenological research papers are written in a way that invites the reader to enter into the phenomenon, and to reflect on its meaning in the context of both their personal life and professional role. The inquiry model known as interpretative phenomenological analysis (IPA), developed by J. A. Smith and colleagues (2009), offers an accessible and practical introduction to phenomenological research. Many valuable IPA studies of therapy topics have been published. Closer and more detailed accounts of what is involved in doing phenomenological research, can be found in the writings of Linda Finlay (2008, 2013, 2014) and Max van Manen (2016). Within phenomenological research, the steps of phenomenological reduction and horizontalisation are explicated and visible – they unfold slowly, as the researcher engages with an interview transcript. In therapy, by contrast, these processes are taking place in the moment. Carrying out this kind of research analysis, or reading research papers, can therefore be viewed as an opportunity for acquiring skills that are used in therapy.

### Existential therapy techniques

One of the distinguishing features of the existential approach to therapy is its lack of concern for technique. As van Deurzen (2001: 161) observes: 'the existential approach is well known for its anti-technique orientation . . . existential therapists will not generally use specific techniques, strategies or skills, but instead follow a philosophical method of inquiry'. This stance is consistent with existential principles and values – conceptualising the work of therapy runs the risk of creating an 'I-it' relationship within which the client is an object of scrutiny rather than a living, intentional being. By contrast, a 'philosophical method of inquiry' suggests a therapy process that is based in mutual dialogue and shared meaning-making.

Nevertheless, a therapist always has some kind of technique or pattern of working with a client. Existential therapy has close ties with psychodynamic and humanistic therapies, and in practice most existential therapists make use of methods from these approaches, such as empathic reflection, free association, interpretation, exploring dreams, and two-chair work. Some existential therapists also

make use of structured exercises similar to CBT, such as worksheets, diaries, and homework tasks. Following van Deurzen (2001), it is perhaps reasonable to suggest that it is not that existential therapists do not use techniques – they do – but that what is important to them is that the technique serves an existential purpose. For example, although an existential therapist might appear to be using the person-centred technique or skill of empathic reflection, their intention in doing this is to engage in phenomenological inquiry. Similarly, an existential therapist may appear to be using the psychodynamic technique of interpretation, but their intention is to invite the client to consider underlying existential themes.

A useful summary of what existential therapists do in their work with clients can be found in Cooper (2012). An aspect of existential technique that he emphasises in this account is the use of *challenge*. An existential therapist is likely, in a respectful and gentle manner, to press a client to face up to aspects of their existence that they have been avoiding. One way that this might take place is to encourage the client to stay with a thought or feeling, or to remind them when they have changed the topic in an apparent desire to avoid talking about a specific aspect of an issue. This technique is consistent with an existential emphasis on the importance of having a genuine and authentic relationship.

In a qualitative research study using conversation analysis, Kondratyuk and Peräkylä (2011) carried out a detailed comparison of how an existential therapist and cognitive therapist handled the task of encouraging a client to pay attention to what was happening for them in the present moment (i.e. in the room with the therapist). This study is notable in comprising the only published micro-analysis of existential therapy techniques. Kondratyuk and Peräkylä (2011) described what the existential therapist was doing as guidance into immediacy. This was significantly different from the approach the cognitive therapist had employed in a similar scenario. The key difference was that, rather than just asking the client to make this shift, the existential therapist subtly managed the process so that the client was positioned not just to report on their experience, but actively to explore its meaning.

A practice protocol specifying different stages of existential therapy (i.e. how different techniques fit together and build on each other) has been developed by Rayner and Vitali (2016, 2018), in the context of a project to establish the credibility and relevance of short-term existential therapy in frontline health service settings. Rayner and Vitali (2018) suggest that therapy needs to start with a phase in which the therapist seeks to engage with the client in a process of *de-objectifying psychological distress*: rather than defining distress in terms of symptoms or diagnoses, the client learns that what the therapist is interested in is the client's own views and experiences. Having established this ground rule, therapy can then move on to a stage of *agreeing the goals of therapy* in terms of what is actually meaningful and realistic for the client. Then, within each of the areas in which the client wishes to make changes in their life, the therapist actively elicits *descriptions and narratives* – this involves the application of a phenomenological method of inquiry. As the client generates rich descriptions of relevant areas of experience, the therapist begins to *promote the client's own hermeneutic work* in the form of supporting the client to make sense for themselves of what has been brought forth. This leads to an appreciation by the client of 'worldviews and givens' – the basic realities of the world and life that they inhabit and have created. This appreciation includes awareness of choices that the client has made and may make in the future. Finally, the client enters a phase of *experimentation in the world*, where they create new experiences by taking responsibility for themselves in new ways, based on what they have learned in therapy. Ideally, at the end of all of this, the client would have begun to adopt a new attitude to life.

### Box 13.3: Yalom's 'missing ingredients'

In the introduction to *Existential Psychotherapy* (1980), Irvin Yalom tells the story of enrolling in a cooking class taught by an elderly Armenian woman who spoke no English. He found that, as much as he tried, he could not match the subtlety of flavouring that his teacher achieved in her dishes, and was unable to understand why. One day, he observed that, en route from the table to the

oven, she ‘threw in’ to each dish various unnamed spices and condiments. Yalom (1980: 6) reports that he is reminded of this experience when he thinks about the ingredients of effective therapy. He suggests that although therapy textbooks and training programmes specify what a therapist should do in great detail, ‘when no one is looking, the therapist throws in the “real thing”’. What is the ‘real thing’, the essential ‘missing ingredient’ in therapy? Yalom (1980) suggests that the important ‘throw-ins’ include compassion, caring, extending oneself, and wisdom. He characterises these ingredients as central existential categories, and goes on to argue that the most profound therapy always needs to address one or more of the four ‘ultimate concerns’ in life:

- 1 Confronting the tension between the awareness of the inevitability of death and the wish to continue to be.
- 2 Acceptance of the possibilities of freedom, including the terrifying implication that each of us is responsible for our actions.
- 3 The ultimate experience of isolation – each of us enters existence alone and must depart from it alone.
- 4 Meaninglessness – what meaning can life have, if there are no pre-ordained truths?

Yalom (1980) takes the view that all effective therapists are sensitive to these ‘ultimate concerns’ and ingredients: the study of existential thought enables a therapist to place these elements at the heart of their work with clients.

## Existential therapy in action

In order to understand how existential principles and techniques operate in practice, it is helpful to look at some concrete examples of how this approach to therapy has been used by different therapists working with different client issues.



### Case study 13.1: The case of Louise – single-session existential therapy

Louise was a student from an affluent American family, living away from home for the first time while studying in London. When her new flatmates defrauded her of some money, she became hugely upset and unable to continue with her studies. Her tutor advised her to visit the college counsellor. Du Plock (1997a) describes how he used an existential approach in his work with Louise. This was a situation in which the client was certainly not attending therapy in order to explore existential issues. In addition, because of pressure of time, they had only one session. Nevertheless, a therapeutic process took place that was clearly informed by existential principles. Du Plock (1997a: 73) described his first impression of Louise as a self-confident young woman wearing smart clothes. For Du Plock (1997a), an important step in being able to engage with the ‘lived experience’ that was troubling Louise was to ‘bracket off’ these first impressions, and be open to what else was there. He was then able to help Louise to express and be aware of the aspects of her way of ‘being in the world’ that were implicated in the incident with her flatmates, including her sense of herself as a person and her way of relating to others. She became able to see that the way she had been with her flatmates had resulted in them viewing her as an arrogant ‘rich bitch’ who deserved to be exploited. She came to a point of being able to understand the whole incident as an opportunity for learning that supported her sense of herself as being open and adventurous. By the end of one extended session, Louise had resolved her emotional turmoil around what had happened, and was ready to move on.



## Existential therapy for sexual difficulties

One of the leading figures in the counselling and psychotherapy professional community in Britain, Meg Barker, has written about her experience as an existential therapist working with sexual difficulties (Barker 2011). She begins by outlining the multiple levels of taken-for-granted knowledge and understanding with which she is presented by most of her clients: ideas about the biology of sex, gender relationships, the purpose of sex therapy, and knowledge about sexual dysfunctions gleaned from popular media. These dominant understandings are important, and need to be respected, because they are part of the reality of the client. Nevertheless, an existential approach seeks to offer a different way of talking, one that explores the client's lived experience. For Barker (2011), an existential perspective provided many ways of making sense of the dilemmas of lived experience that were then disclosed, for instance ideas about ways of being in the world, and embodiment. These conversations allowed clients to arrive at a better understanding of what their sexual difficulties meant to them, and to make choices that might include established techniques of therapy intervention, or involve more idiosyncratic and personal solutions.

## Existential therapy for long-term schizophrenia

The existential psychiatrist and psychotherapist R. D. Laing used an existential approach in the 1960s and 1970s to work with individuals who had been diagnosed as suffering from schizophrenia, and had typically undergone in-patient hospitalisation and medication or electroconvulsive therapy. Laing's writings offer an account of therapy in extreme situations, with people who had been severely damaged by adverse life experiences. These were people who were often withdrawn and uncommunicative, whose moods might suddenly change for little apparent reason, and whose speech was hard to understand. Although Laing's later career was marked by alcoholism and a failure to deal with the impact of fame, his early contributions to psychiatry and therapy have left a lasting legacy marked by an edited volume to honour the 50-year anniversary of the publication of his first book (Itten and Young 2012) and the 2017 movie *Mad to be Normal*. One of the most powerful aspects of Laing's approach was his capacity to be present, listen, and work hard to make sense of what he was seeing and hearing.



### Case study 13.2: The case of Sarah – overcoming loss and life-threatening uncertainty

A case study by Christian Schulz (2015) represents a unique contribution to understanding the process of existential therapy. The client, Sarah, was a young woman and mother who experienced the loss of her husband and father at the same time as being struck by a heart condition that required a transplant. Schulz was a hospital-based therapist who used an existential approach to work with Sarah for more than 120 sessions over a period of two and a half years. This case is notable for the level of detail that is provided around the process of therapy, in the form of verbatim records of therapy conversations, and the systematic way in which information about the case was analysed and presented, using heuristic qualitative methodology. The case report includes not only examples of existential principles and techniques such as caring, authenticity, horizontalisation, and experimentation in the world, but also the experience and existential reflections of the therapist as he was applying these principles. Schulz (2015) offers an account of how the process of phenomenological inquiry into Sarah's experience, throughout the therapy, led to the emergence of two main existential themes: waiting and despair. This study offers an insightful and moving description of both the meaning of these fundamental aspects of existence, and the way in which a therapist might work with them.



To be able to do this, he needed to be able to bracket off assumptions about mental illness. His exploration of the lived experience of individuals who had undergone serious mental health problems resulted in the development of new existential concepts. Laing created the term *ontological insecurity* to describe a state of fundamental self-doubt experienced by many people who have been exposed to abusive social environments. 'Ontology' in Laing's writing refers to the person's sense or understanding of their own *being*. Laing (1960: 39) describes an ontologically secure person as someone who will 'encounter all the hazards of life, social, ethical, spiritual, biological, from a centrally firm sense of his own and other people's reality and identity'. By contrast, an ontologically insecure person lacks this 'firm sense of . . . reality and identity', and experiences themselves – and the world – as unreal, insubstantial. Laing (1960) identified three ways in which ontological insecurity is expressed by a person: *engulfment*, where the person fears that any relationship will completely overwhelm their fragile sense of identity; *implosion*, a sense of utter emptiness, a belief that all the person can ever be is an 'awful nothingness'; *petrification and depersonalisation*, a dread of being turned from a living person into stone, or into a robotic state or a 'thing'. Laing (1961) argues that a state of ontological insecurity is gradually built up through relationships in which the person is exposed to repeated disconfirmation by significant others in their life, or trapped in collusive relationships. He regarded recovery, in the direction of ontological security, as a slow process that required a supportive and authentic community life in addition to any psychotherapeutic help that might be available.

### Box 13.4: The therapist's 'existential touchstones'

Mearns and Cooper (2005) use the term 'existential touchstones' to refer to a source of personal knowing that is fundamental to the capacity to offer a therapy relationship. A personal or existential touchstone is a memory that has deep significance for a person, and from which they have learned something vital about the meaning of being human. Mearns and Cooper (2005) defined touchstones as events and self-experiences from which a therapist could draw strength, and that they could use to make them more open to, and comfortable with, different types of relationships and human experiences. An example of an existential touchstone might be the experience of the death of a parent in childhood, which led to a capacity both to accept the reality of intense emotional pain and to know that love and connectedness are possible even in the face of such despair. From an existential perspective, therapist personal touchstones can be seen as aspects of life that have been so important and difficult for them, that they have been forced to move beyond taken-for-granted assumptions and ways of thinking, and engage in personal phenomenological inquiry that has opened up a richly nuanced understanding of that area of experience.

## Conclusions

Existential therapy is a global therapy, with therapists and training institutes in more than 40 countries (Correia et al. 2014). Existential authors such as Frankl, Laing, and Yalom have achieved public recognition beyond the boundaries of the psychotherapy and mental health professions. The ideas and methods of existential therapy have been highly influential within the world of therapy for many years. Existential therapy seeks to address 'ultimate concerns'. Whereas other forms of therapy may be more effective in helping the person to cope with the pressures of everyday life, and deal with symptoms, existentially informed therapies strive to enable a person to do something else, which is to make fundamental *choices* about who they are and what direction their life will take. Every therapeutic intervention, in any form of therapy, is accompanied by an implied existential meaning, which can be regarded as a fundamental process that operates across all the different therapeutic

approaches. Although existential therapy is more philosophically oriented than evidence-informed, there is still a substantial body of research that supports its effectiveness across a range of client presenting problems (Craig et al. 2016; Vos et al. 2015b).



### Topics for reflection and discussion

- 1 Choose any *one* of the approaches to therapy discussed in earlier chapters (e.g. psychodynamic, CBT, person-centred therapy, etc.). To what extent, and in what ways, does that approach encourage conversations about existential issues (the basic experience of being with others, living in time, agency and intentionality, embodiment, authenticity, etc.)?
- 2 What are the strengths and weaknesses of an existential approach to therapy compared with other approaches? Are there groups of clients, or problem areas, where existential therapy might be *more* or *less* appropriate or helpful?
- 3 What are the existential issues in your own life? What are your strategies for managing, or living with, these issues?
- 4 How attractive or relevant is existential therapy for you, in respect of difficulties and challenges that you are experiencing in your life? What would you gain from spending time with a good existential therapist?

### Suggested further reading

For anyone who has not read any of the primary existential philosophy texts, a useful starting point is *At the Existentialist Café: Freedom, Being, and Apricot Cocktails with Jean-Paul Sartre, Simone de Beauvoir, Albert Camus, Martin Heidegger, Maurice Merleau-Ponty and Others* (Bakewell 2016). This book tells the story of the lives and loves of key figures in existential thought, in an accessible and interesting style. It explains what each of them was trying to achieve in their work, and offers a basis for deciding which of these philosophers might be worth reading in their own right. The best introductory textbooks on existential therapy are the *Existential Counselling Primer* and *Existential Therapies*, both by Mick Cooper (2012, 2017). The writings of Irvin Yalom have brought existential ideas to the attention of a worldwide public audience for several decades, from his first non-academic book (Yalom 1989 – a collection of fictionalised case studies from his own work with clients) through to his recent autobiography (Yalom 2017).

# Chapter 14

## Narrative approaches to therapy

<b>Introduction</b>	<b>208</b>
<b>Philosophical context</b>	<b>209</b>
<b>Narrative therapy</b>	<b>211</b>
Externalising the problem	212
Enlisting community resources	214
Therapist style	214
The absent but implicit	215
Using audiences	215
Visual and metaphoric modes of storytelling	216
Working with communities	216
Research on narrative therapy	217
The significance of narrative therapy	218
<b>Other narrative-informed approaches to therapy</b>	<b>218</b>
Constructivist therapy	219
Solution-focused therapy	221
Dialogical therapy	225
The radical theatre tradition	226
<b>Conclusions</b>	<b>227</b>
<b>Topics for reflection and discussion</b>	<b>228</b>
<b>Suggested further reading</b>	<b>228</b>

### Introduction

Our everyday lives are permeated by narrative. We tell ourselves and each other stories all of the time. We structure, store, and communicate our experiences through stories. We live in a culture that is saturated with stories – myths, novels, television soaps, office gossip, family histories, and so on.

This perspective has found expression within the counselling and psychotherapy field in the idea that individuals and groups create their personal and social realities through the use of *language* – metaphors, stories, ways of talking. In terms of therapy practice, the implication is that problems can be understood as brought into being through language. This idea leads to the notion of therapy as *conversation* – the task of the therapist is to facilitate a conversation within which new meaning can be found, new ways of talking that can result in new forms of action that promote and support social justice and connection.

The intention to engage in conversation and collaboration with a person who is seeking help implies that the person has something positive to offer, in terms of ideas about how to resolve their problem. Conversational approaches to counselling and psychotherapy therefore imply a *strengths* perspective. There exists a critical, sceptical dimension to such a stance, in terms of its commitment to questioning and deconstructing the idea of the therapist as expert; in collaborative therapies, both the client and the therapist are experts.

The present chapter offers an introduction to counselling and psychotherapy approaches that have developed ways of using a language-informed perspective in work with clients. Although these approaches each have somewhat different origins and influences, in terms of philosophy and practice, they all share a central guiding conception that close attention to language, conversation, and storytelling sits at the heart of effective therapy.

## Philosophical context

The therapy approaches discussed in this chapter represent a significant philosophical shift away from the assumptions that underpin mainstream theories of counselling and psychotherapy, such as psychodynamic and cognitive-behavioural. These mainstream approaches reflect, in their different ways, a common-sense or 'realist' view, widely held by people in modern societies that there exists a single objective, knowable reality. For a psychodynamic therapist, the unconscious, or transference, really exists. For a CBT therapist, dysfunctional cognitive schema really exist. However, it is possible to take a different view. It is possible to regard the unconscious, transference, or cognitive schema as *constructions* that people place on experience. For example, if a client mistrusts their therapist, this is an event that can be described in many different ways. Some people (e.g. psychodynamic therapists) would describe what was happening in terms of transference. Other people might describe it as a reaction to the professional distance adopted by the therapist, as an unremarkable and normal reaction to anyone in a position of power, as being due to a biochemical imbalance in the client's brain, or in many other ways.

These different 'ways of seeing' are not neutral. They have consequences, and lead to different courses of action. For instance, a transference perspective on the part of a therapist might lead to questioning about the early experiences that predisposed the client to lack trust, while a biochemical perspective might lead to questioning about other symptoms of a depressive illness. By contrast, regarding lack of trust as a reaction to power might lead a therapist to look for ways of achieving more equality, perhaps by talking about their own experience. On a moment-by-moment basis, therefore, the ways in which we make sense of phenomena and events results in different ways of relating to each other, and different actions in the world.

This central insight – that reality and experience are 'constructed' through language, talk, and conversation – has itself been interpreted differently by various groups of philosophers. An appreciation of these philosophical standpoints is necessary in order to make sense of the alternative directions that have been followed by the various therapy approaches that are explored in this chapter. There are four philosophical perspectives that are particularly relevant here: constructivism, social constructionism, post-structuralism, and postmodernism.

*Constructivism* refers to the idea that reality is constructed at an individual level. Constructivists are interested in the processes by which individuals make sense of the world, through the words and

metaphors they use, and the stories they tell. Constructivism has been highly influential in education, because it draws attention to the fact that students do not merely take on board everything that their teachers tell them, but actively choose to pay attention to ideas that interest them, and then assimilate these ideas into their own individual *pre-understanding* of the topic. Constructivist therapists are highly sensitive to the active ways that their clients create meaning (e.g. by paying attention to some areas of experience more than others) and to the client's use of language and metaphor. Within psychology and therapy, *personal construct theory* represents the most fully articulated constructivist approach (Butt 2008; Fransella 2005).

*Social constructionism* refers to the idea that the meaning of phenomena or events is constructed by people working together (Burr 2003; Gergen 1999; Lock and Strong 2010). Specifically, the way that a thing is understood will depend a great deal on historical factors – how it has been understood in the past – and how this ‘archaeology’ of understanding is expressed in the meanings of words. Social constructionists are particularly interested in talk and conversation, because it is in the interaction between speakers that certain constructions of reality are adopted, and other constructions are set aside. Social constructionist therapists tend to focus on the types of conversation that clients hold with other people in their lives, and in the way that the client positions themselves in relation to cultural discourses.

*Post-structuralism* is a philosophical position that is complex and elusive to define. However, at its most straightforward level, it is a perspective that questions the assumptions of structuralist approaches to understanding. A structuralist way of understanding individuals or society is one that believes that it is possible to explain events and behaviour in terms of some kind of underlying structure. For example, on a superficial level the social world may seem complex and confusing, but at a deeper level this complexity can be explained in terms of an underlying class structure (a Marxist explanation). Similarly, the behaviour of an individual person can be explained in terms of an underlying personality structure (a psychological explanation). Post-structuralism, by contrast, questions any such ‘totalising’ explanation based on an all-knowing ‘God’s eye view’ of things, and instead seeks to understand people and events by carefully describing and analysing (or ‘deconstructing’) what people are actually doing. In relation to therapy, a valuable example of post-structuralist thinking can be found in Michael White’s (2004) discussion of ‘folk psychology’ (the way that ordinary people think about what it means to be a person) versus the hypothetical psychological structures constructed by psychologists.

*Postmodernism* is a sociological perspective, rather than a philosophical position. Postmodernism characterises contemporary society as moving in the direction of increasing scepticism about the validity of universal ‘truths’ such as psychoanalysis, Marxism, or Christianity, and replacing these ‘grand narratives’ with a more pragmatic ‘local knowledge’ that reflects the interests of people in particular times and places.

In addition to these broad philosophical perspectives, there are also a number of individual philosophers whose writings have influenced the therapy approaches discussed in this chapter. The work of Mikhail Bakhtin has elucidated the nature of conversation, in terms of drawing attention to the idea that different ‘voices’ are apparent in a person’s speech, and that the act of talking implies the presence of an audience (Bakhtin 1981). The writings of John Shotter have been influential in integrating various philosophical perspectives on language, in terms of their relevance to psychology and psychotherapy (Shotter 1993).

The role that these philosophical positions play, in relation to the approaches to counselling and psychotherapy outlined in this chapter, can be quite confusing for those who do not have a grounding in philosophy. One of the reasons for the difficulty of this philosophical literature is that much of it is not written in response to issues in psychotherapy (or even to issues in psychology), but has

been primarily addressed to questions in other disciplines. Although each of these philosophical perspectives has some distinctive features, there is also a great deal of overlap between them – they all start from a constructivist and anti-realist standpoint, based on the idea that people construct or co-construct the realities that they live within. Key sources that discuss these philosophical ideas and their relevance to counselling and psychotherapy include White and Epston (1990), Kvale (1992), Lock and Strong (2012), McNamee and Gergen (1992), and Anderson and Gehart (2007).

## Narrative therapy

Narrative therapy is the most highly organised, pervasive, and influential of the constructionist approaches to therapy discussed in this chapter. The main inspiration for narrative therapy came from the work of Michael White and David Epston. Perhaps because they lived in Australia (White) and New Zealand (Epston), these therapists have been able to evolve an approach that is radically different from mainstream therapies. Although their initial training and background was in family therapy, their ideas can be – and have been – used in work with individuals, couples, and groups. Following the publication of *Narrative Means to Therapeutic Ends* (White and Epston 1990), their approach was introduced to new audiences by the books of Parry and Doan (1994), Freedman and Combs (1996), and Monk et al. (1996). Narrative therapy has generated an international network of conferences, training programmes, and publications, based around the Dulwich Centre in Adelaide, Australia, and associated centres in many other countries. More recent developments in narrative therapy theory and practice are summarised in Combs and Freedman (2012), Madigan (2011), and Denborough (2014, 2018).

Narrative therapy is informed by a post-structuralist and broadly social constructionist philosophical position that regards personal experience and meaning as embedded in a culture and shaped by that culture. People are social beings. Personal identity is a product of the history of the culture, the position of the person in society, and the linguistic resources available to the individual. Instead of focusing on ‘self’, narrative therapists look at what is happening within a culture or community, and the relationship between a troubled person (or client) and their community. Narrative therapy has drawn in particular on the ideas of the French post-structuralist philosopher Michel Foucault, who advocated a critical stance in relation to expert knowledge claims, and the replacement of culturally dominant narratives (the stories told by those in power) by the ‘insider’ knowledge that is held by ordinary people.

The key ideas that underpin narrative therapy can be summarised as follows:

- Therapy is a conversation.
- People live their lives within the dominant narratives or knowledges of their culture and family.
- Sometimes, there can be a significant mismatch between the dominant narrative and the actual life experience of the person, or the dominant narrative can construct a life that is impoverished or subjugated.
- The therapist aims to help the client to deconstruct the dominant narrative, reducing its hold over them.
- One of the ways that the therapist does this is to invite the client to externalise the problem, to see it as a story that exists outside of them.
- The therapist helps the client to identify unique outcomes or ‘sparkling moments’ – times in their life when they have escaped from the clutches of the dominant narrative.
- The therapist adopts a *not-knowing* and *de-centred* stance in relation to the client; the client is the expert on their story – they possess crucial *insider knowledge*.
- At the completion of therapy the client may be invited back as a ‘consultant’, to share their knowledge for the benefit of future clients.



- A central aim of therapy is to assist the person to re-author their story and to perform this new story within their community.
- Although much of the therapy is based on conversation and dialogue, written or literary communications such as letters and certificates are used because they give the client a permanent and 'authoritative' version of the new story.
- Where possible, cultural resources, such as support groups or family networks, are enlisted to help a person to consolidate and live a re-authored story, and to provide supportive audiences.

Narrative therapy tends to be of fairly short duration, with high levels of therapist activity. The therapist is clearly warm and affirming, adopting a style of relating to the client that conveys hope and a belief that the client has a capacity to grow and change in positive ways. Narrative therapy is based in a relational understanding of identity, in which a person's sense of self is not viewed as a fixed, 'boundaried' psychological structure, but instead is seen as being distributed, performed, fluid, and co-constructed (Combs and Freedman 2016).



### Case study 14.1: Re-authoring therapy – Rose's story

An example of how narrative therapy can be applied in individual therapy is provided by the case of Rose (Epston et al. 1992). Rose had lost her job as a receptionist/video-camera operator at an advertising agency, because she would 'crack up' and burst into tears if interrupted while completing a work task. When she met David Epston, she told him that 'I don't have a base inside myself'. He replied, 'There must be a story behind this. Do you feel like telling me about it?' She then talked about the physical abuse she had received from her father, a well-respected parish minister. Following this first session, Epston sent her a lengthy letter, in which he wrote about how pleased he had been to meet up with her and hear her story of 'protest and survival' against what she had experienced as an attempt to destroy her life. He added that he hoped that he might be able to assist her to write a 'new history of events in her life', that would open up a different kind of future. The next therapy session was one month later. During the interval, Rose had applied for and secured a job as a chef (her preferred occupation), and had been so successful in this role that the restaurant owner had left her in charge while he took his holidays. She had renewed her relationship with her mother, and had met with each of her siblings to talk through the message of the letter with them. She felt her life was now 'on the right track'. There was one other therapy session, and then six months later Rose was invited to join her therapist as a 'consultant to others' so that 'the knowledges that have been resurrected and/or generated in therapy can be documented' (Epston et al. 1992: 106). During this consultation meeting, Rose explained that the letter had offered her a crucial 'point of reference' that she could look back at, read through, and arrive at her own conclusions.

### Externalising the problem

One of the distinctive features of narrative therapy is the procedure known as 'externalising the problem' (Morgan 2000; White and Epston 1990). Many clients enter therapy with a sense that the problem is a part of them; it is inherent in who they are as a person. When this happens, the person can all too readily arrive at a 'totalising' position where their whole sense of self, and the way they talk about themselves, is self-blaming and 'problem-saturated'. The process of externalising the problem involves separating oneself and one's relationships from the problem, allowing one to take a lighter approach to that which previously has been considered a 'deadly serious' issue.

More than this, from a narrative point of view, the ‘problem’ is understood as arising from the ‘dominant narrative’ that has shaped the client’s life and relationships. It is as though the dominant narrative or story is being told or enacted through the life of the client, leaving no space for alternative narratives. Externalising the problem opens up a space for telling new types of story about the problem, for re-authoring. But how is this achieved?

The first step in externalising is naming the problem. Ideally, the problem should be defined or phrased in language used by the client. It is normally helpful to make the problem label as specific as possible, and to use humour or imagery. So, for example, with a client who begins therapy referring to a problem as ‘panic attacks’ or ‘depression’, it may be useful to agree on a more colloquial problem label, such as ‘scary stories’ or ‘the influence of unreachable standards of perfectionism’. Terms such as ‘anxiety’, ‘panic attacks’, or ‘depression’ may be elements of the dominant discourse of mental health that might have oppressed the client, so even a shift of label away from diagnostic terminology in the direction of everyday language may have the effect of beginning a process of re-authoring.

The next step is to explore such issues as: how does the problem stay strong, and how does the problem influence your life? White and Epston (1990) refer to this phase as ‘relative influence questioning’. The purpose of these questions is to map out the influence of the problem, and in doing so increasingly to draw a distinction between the person and the problem story (White 2007). While this is happening, the therapist is alert for the appearance of unique outcome stories, which are stories of times when the problem did not dominate the person, or was not strong. These new or ‘sparkling moment’ stories form the basis for re-authoring. The task of the narrative therapist is to enable the client to elaborate on these unique outcomes and find audiences for them.



### Case study 14.2: Externalising in action – the Sneaky Poo story

Nick was six years old, and had a long history of encopresis. Hardly a day would go by without a serious incident of soiling: the ‘full works’ in his underwear. Nick had befriended the ‘poo’. He smeared it on walls and hid it behind cupboards. His parents, Sue and Ron, were miserable, embarrassed, despairing. They went for therapy to Michael White’s clinic. Through a series of ‘relative influence’ questions, he discovered that the poo was:

- making a mess of Nick’s life by isolating him from other children;
- forcing Sue to question her ability to be a good parent;
- profoundly embarrassing Ron and as a result making him isolate himself by avoiding visiting friends and family;
- affecting all the relationships in the family.

However, in response to a further series of questions that mapped the influence of what they came to call Sneaky Poo on the family, they found that:

- there were some occasions when Nick did not allow Sneaky Poo to ‘outsmart’ him;
- there were also times when Sue and Ron did not allow Sneaky Poo to defeat them.

White built on these ‘unique outcomes’ by inquiring just how the individual family members managed to be so effective against the problem. Did their success give them any ideas about ‘further steps they might take to reclaim their lives from the problem’? All three of them could think of ways forward. Nick said he was ‘ready to stop Sneaky Poo from outsmarting him so much’. At their next session, two weeks later, much had changed. In that time, Nick had only had one very

minor accident. He had 'taught Sneaky Poo a lesson'. Sue and Ron had started to shift from their states of stress, isolation, and embarrassment. On the third meeting three weeks later and at a six-month follow-up, everything continued to go well. White encouraged them to reflect on what their success against Sneaky Poo said about their qualities as people, and the strength of their relationships (White and Epston 1990: 43–48).

## Enlisting community resources

Narrative therapy is not primarily an individual-centred approach, but is a way of working in the space between the person and the community, drawing on each as necessary. In many respects, narrative therapy could be more accurately described as 'social therapy': the client is encouraged to develop a social network that will support them in their preferred identity and way of being. Epston and White (1992) describe therapy as a *rite de passage*, through which the person negotiates passage from one status to another. In a *rite de passage*, the person first undergoes a separation stage, when they become detached from their previous niche or social role. They then enter a liminal stage, a time of exploration and confusion, and then finally proceed to reincorporation, when they re-enter society in a new role. The case of Rose, described earlier, illustrates this process well. At the start of therapy Rose was performing an almost child-like, dependent role in society, while at the end she had adopted a quite different, highly adult managerial role as head chef in a restaurant.

For narrative therapists, this process involves investing in the construction of supportive networks. A good example of this kind of situation is work with women experiencing difficulties in controlling their eating (Maisel et al. 2004). The dominant cultural and family narratives around food, women's bodies, and dieting are so powerful (in fact, constitute a major international industry) that it can be very difficult for women to find a space to tell their own story, particularly around 'unique outcomes', such as moments of resistance to the pressure to be thin. Epston et al. (1995) describe the foundation of the Anti-Anorexic/Bulimic League, which has been conceived not as a support group but as an 'underground resistance movement' or 'community of counter-practice', set up to promote anti-anorexic/bulimic knowledges. The point here is that resistance to the anorexia/bulimia narrative requires joint action, sharing knowledge and resources, and that individuals stand little chance against the huge oppressive power of anorexia/bulimia.

## Therapist style

One of the consequences of the collectivist focus of narrative therapy has been a questioning of the value of traditional one-to-one therapy as an effective site for constructing new stories. There are many pressures on the therapist in individual counselling and psychotherapy to resort to an expert role, and subtly (or not so subtly) to impose their dominant mental health narrative on the patient or client. Narrative therapy is part of a tradition in therapy that advocates that it is better for therapists to adopt a more egalitarian and collaborative stance (Gergen 1996; Gergen and Kaye 1992). This involves adopting a 'de-centred' position, in which the relationship between the client and other people in their life is considered to be much more important than their relationship with their therapist. For example, Michael White and other narrative therapists consistently highlight the contribution to healing and recovery made by other people in the client's life. Narrative therapists also espouse a 'not-knowing' attitude, in which they strive to keep an open mind in respect of the meaning of the client's experience: the client is the expert on their story and how to change it (Anderson and Goolishian 1992; Hoffman 1992). White (1997) also argued that professional training can have the effect of socialising a therapist into a particular way of making sense of people, grounded in their theoretical model. This cuts the therapist off from what they already know, the 'folk wisdom' that is grounded in the diverse, historical, and local relationships and communities within which they live.

For White (1997), it is essential for therapists to remain in touch with the everyday life roots of their capacity to care for others.

## The absent but implicit

The concept of 'absent but implicit' refers to a particular way of listening that is characteristic of narrative therapy practice (Carey et al. 2009). The key principle here is that when a person talks about a problem, they are not just describing their difficulties, but are also at the same time invoking an implicit contrast with 'what the problem is not'. For example, a person who invests energy in a vivid description of how hopeless and depressing life is, is, at least in part, conveying an underlying assumption that a hope, purpose, and pleasure are preferred or desired qualities. Similarly, stories about hopelessness and depression contain, between the lines, further stories about how the person has survived or resisted depression over a period of time. In acknowledgement of these aspects of the ways in which storytelling is structured, narrative therapists practise 'double listening' (listening for the implicit as well as the overt content of the story) and invite the client to share what is 'absent but implicit' in ways that allow them to acknowledge and make use of their strengths, accomplishments, and positive attributes.

## Using audiences

Narrative therapy sessions may involve the use of a reflecting team, consisting of three or more therapists or trainees who sit at the back of the room, behind the client. They do not actively participate in the main part of the session. Toward the end of the therapy session, they take centre stage and share their experience as witnesses and observers of the life story of the client (or couple or family). Although this procedure draws on a long tradition in family therapy, White (1995) emphasised that the intention is not, as in other family therapy ways of using this technique, to interpret the client's story in theoretical terms, or to offer a therapeutic response. The aim, instead, is to offer a response that will allow the client to make connection with the stories and experiences of others, in ways that would 'thicken' their story. Members of the reflecting team are invited to consider such questions as:

What caught your interest?

What touched or moved you in what you heard?

As you listened, which expressions caught your attention or captured your imagination?

What did this have you thinking about, in relation to your own work and life?

Which aspects of your own experiences of life resonated with the images and expressions of the teller?

What is it about your own life that meant you were touched in this way?

Where does hearing this take you?

How will it contribute to possibilities in your own life?

From the perspective of the client (or family), the responses of the reflecting team can have the effect of enabling them to view their experience from a range of perspectives. The role of reflecting team member gives permission to talk in more evocative and personal ways, in contrast to the role of therapist. Further guidelines on the use of reflecting teams in narrative therapy can be found in Morgan (2000) and White (1997). A study that analyses the ways in which the reflecting team procedure can facilitate change in the ways in which a client talks about their life can be found in Wahlström (2006).

In addition to reflecting teams, narrative therapy may also make use of 'outsider witnesses' to create 'definitional ceremonies' in which stories that express the preferred identity of a person (as opposed to a stigmatised or marginalised identity) can be shared with and witnessed by other

members of their community. For example, White (2007) described a case in which a former client with an eating difficulty (and then, at a later stage, her parents) took part in a therapy session with a new client (and her family) who were struggling with a similar problem. White (2007) has developed a structure that can be followed to ensure that the maximum value can be gained from such encounters. For example, the witness is asked to describe what they noticed in the client's story, and to re-tell the story in their own words. The event provides a structured ceremony that honours the accomplishments of the client (i.e. contributes to a process of more positively re-defining their sense of identity) and allows them to begin to see that their story can be meaningful and helpful for others.

Beyond these ways of using audiences within therapy sessions, narrative therapists encourage clients to find appropriate audiences within their everyday life. For instance, a therapist might ask the client to think about who would be interested in hearing about their new ways of dealing with a problem. Narrative therapists use written documents, such as letters and certificates, to create a tangible record of the re-authored story of the client. These documents not only serve as a reminder to the client, but can be shared with family members, friends, and others.

## Visual and metaphoric modes of storytelling

A range of activities are available that offer clients opportunities to use visual images as a means of structuring storytelling. The most widely used of these techniques is the Tree of Life, developed by Ncube (2006), a Zimbabwean therapist working in South Africa, and David Denborough from Australia (Denborough 2008, 2018), to facilitate narrative groupwork with children affected by HIV/AIDS in southern Africa. Participants draw their own personal 'tree of life', including their 'roots' (where they come from), their skills and knowledges, their hopes and dreams, as well as the special people in their lives. Participants then join their trees into a 'forest of life' and, in groups, discuss some of the 'storms' that affect their lives and ways that they respond to these storms, protect themselves and each other. The aim of the Tree of Life is to enable people to speak about their lives in ways that strengthen their relationships with their own history, their culture, and significant people in their lives. The success of this technique with people from many different cultural settings and life difficulties reflects the meaningfulness, in all cultures, of the tree as a metaphor and growth as a central principle of life (Denborough 2018).

Similar activities have been devised that draw on other metaphors – Seasons of Life, Recipes of Life, Crossing the River, Kite of Life, Rhythm of Life, Narratives in the Suitcase, Smartphone of Life, and Bicycle of Life – or informed by metaphors from songwriting and sporting activities such as football, wrestling, and sailing (Abu-Rayyan 2009; Chow 2015; Denborough 2008, 2018; Douge 2010; Hegarty et al. 2010; Leger 2016; Mascher 2002; Portnoy et al. 2015; Ricks et al. 2014; Rudland Wood 2012).

Denborough (2018) suggests that these therapeutic activities represent means of implementing narrative principles in ways that are accessible and acceptable for people for whom the idea of psychotherapy may not be culturally resonant, because their starting point is in types of experience ('treasured themes') that are familiar. In addition, these activities do not require a person to speak in the first person about their problems – instead, they provide a channel for meaning to be conveyed through imagery and metaphor rather than direct speech. They are also techniques which are flexible, energising, and fun, and which allow both individual self-exploration and group support and solidarity. The richness and diversity of examples of metaphoric storytelling structures arises from the fact that narrative therapy is not based on a narrowly defined therapy protocol, but on a core set of principles and ideas that can be implemented in many different ways to accommodate local circumstances.

## Working with communities

One of the distinctive aspects of narrative therapy is that it involves working with communities as well as with individuals and families. This approach is consistent with the underlying principle of narrative therapy that individuals are always part of a social group, and that overcoming individual life difficulties involves building networks of support with others. It also reflects what Denborough

(2018) describes as an intention to 'democratise' therapy so that it can be provided not only by highly trained professionals, but also by key community and family leaders who may not have had the privilege of extensive schooling/education. Indeed, White (2001) argued that people understand and respond to problems in living on the basis of common-sense insider knowledge and 'folk psychology' and that professionalised, technical theories of therapy may in fact be more of a hindrance than a help. Examples of initiatives in which narrative therapists have worked in partnership with community groups can be found in Denborough (2006, 2008, 2018), Denborough et al. (2006, 2008), and Wingard et al. (2015). An important point of connection between individual suffering and work that primarily focuses on economic development or overcoming political oppression is the concept of 'neoliberal fatalism', which offers a way of making sense of one of the key ways in which political and economic ideology impacts on individual well-being (Denborough 2018).

In one compelling case study, Denborough (2018) describes a process in which a group of Muslim refugees in Australia compiled a document about their experiences of overcoming difficulties, which was then used to facilitate the construction of a parallel document (and reply) by other groups in Syria and elsewhere. Other projects have been based on developing forms of support that making use of local traditions and practices (Wingard et al. 2015). An important aspect of this line of work is that it is not limited to a merely psychological way of making sense of problems, but also takes account of political and economic dimensions – the book by Denborough (2018) includes an immensely moving and inspiring account of the struggle of communities in Papua to maintain their way of life in the face of massive state violence and oppression. At a theoretical level, because the approach is ultimately based on concepts and research from critical social science, community-based narrative therapy is able to draw on the writings of political and social action theorists to augment its understanding of such issues.

## Research on narrative therapy

Narrative therapy theory and practice draws on critical political discourse that questions and challenges the power relations that are reflected in mainstream counselling and psychotherapy research. Specifically, the narrative therapy tradition questions the value of research in which the researcher is positioned as an expert who measures or interprets the meaning of the client's experience. Instead, research in narrative therapy has evolved in two distinct directions. The first comprises a form of inquiry that is based on collaborative meaning-making and writing, and which views the products of therapy (e.g. letters and other documents produced by clients and therapists) as research data (Crocket et al. 2004). A second approach has been to use research to describe and evaluate how narrative therapy works in different situations and how it can be improved. For example, O'Connor et al. (1997) used qualitative methods to explore client experiences of narrative therapy in a child and family outpatient clinic in Canada. Interviews were carried out with members of families at different stages in their therapy. The main themes to emerge from this study were that clients valued the ways that therapists treated them with respect and regarded them as the 'experts' on their problems, and described the main outcome of therapy as being the development of personal agency and control over their lives. Some clients reported that they were uncomfortable with some aspects of the narrative therapy procedure, such as being observed.

A further study by the same research group examined therapists' experiences of delivering narrative therapy (O'Connor et al. 2004). The authors found that all the therapists at the clinic were enthusiastic about narrative therapy and believed that it was an effective way of working with their clients. However, they also described some limitations of narrative therapy: it was hard for therapists who had previous training to learn narrative therapy language and methods, it was costly in terms of staff time, and on occasions the information from reflecting teams (where a group of observers reports on their reactions to the family) could be overwhelming. The most significant difficulty, reported by half of the therapists in this study, was that it was hard to adopt a narrative therapy stance when clients reported family violence issues. In such situations, therapists found themselves retreating to a more controlling, rather than collaborative, stance. Ideas from narrative therapy have guided the



development of the ‘innovative moments’ model of the process of therapeutic change (Cunha et al. 2012; Gonçalves et al. 2011, 2012).

There have been relatively few quantitative studies of the outcomes of narrative therapy. Vromans and Schweitzer (2011) found that depressed clients receiving narrative therapy reported benefits equivalent to the outcomes of CBT. Similar findings have been reported in a separate study by Lopes et al. (2014). Looyeh et al. (2014) used a randomised trial design in a study that showed good results for narrative therapy for clients with social anxiety. These are important results, because the authors used a research approach that was based on standard quantitative methods for outcome investigation, and as a result was not particularly sensitive to the distinctive characteristics of narrative therapy. For narrative therapy to yield positive results in this kind of scenario is therefore of some significance.

The studies described above do not seek to provide a comprehensive account of the expanding research literature on the processes and outcomes of narrative therapy, but instead are intended to offer some examples of the kind of work that has been carried out. Overall, research into narrative therapy has provided consistent evidence of its effectiveness across different client groups.

## The significance of narrative therapy

Narrative therapy represents what is currently the clearest and most fully articulated example of the value of adopting a broadly constructionist, language-oriented approach to therapy. Beyond the network of practitioners who explicitly define themselves as narrative therapists, ideas and methods derived from this way of working have been used by therapists from a wide range of different backgrounds, including psychodynamic, CBT, emotion-focused, and existential (Angus 2012; Sanchez and Shallcross 2012). The general relevance and applicability of a narrative perspective on therapy is discussed by McLeod (1997) and Sools and Schuhmann (2014).

The success of narrative therapy can be attributed to a number of different aspects of the way in which it has evolved. It combines a distinctive and carefully thought-through conceptualisation of the nature of problems of living and how they can be ameliorated, along with an array of practical strategies and procedures. The intellectual roots of narrative therapy, in post-structuralist philosophy, social anthropology, and radical politics, give it a novelty or ‘shock’ factor that is often experienced by both therapist and client as transformative and liberating. It is consistent with some of the key emerging themes in contemporary counselling and psychotherapy: an emphasis on the strengths and resources of the client, sensitivity to cultural difference, and a commitment to social justice. In fact, narrative therapy can be viewed as operating at the cutting-edge of each of these areas of therapeutic innovation. At an organisational level, narrative therapy has never been based in universities, has never developed a bureaucratic structure of training and accreditation, and has been clear and unequivocal in its critique of the limitations of mainstream approaches to research. This loose organisational structure, alongside a model of therapy that prioritises everyday language, starting from where the person is, and the importance of local knowledge, has allowed narrative therapy to be an effective intellectual and professional home for innovative therapists from all parts of the world, and to give a voice to oppressed groups of people.

## Other narrative-informed approaches to therapy

While narrative therapy has become a widely recognised and distinctive approach to therapy, with its own journal, publishing house, conferences, and training programmes, it is important to acknowledge that it sits within a wider family of therapy approaches that have started from a similar set of philosophical perspectives, but have developed in different directions. These complementary, narrative-oriented approaches to therapy are the topic of the second half of this chapter: constructivist therapy, solution-focused therapy, dialogical therapy, and the radical theatre tradition.

## Constructivist therapy

Key figures in the cognitive–behavioural approach to therapy, such as Michael Mahoney and Donald Meichenbaum, along with therapists from other approaches, have come together under the banner of *constructivist* therapy. Constructivism can be characterised as resting on three basic assumptions. First, the person is regarded as an active knower, as purposefully engaged in making sense of their world. Second, language functions as the primary means through which the person constructs an understanding of the world. Constructivist therapists are therefore particularly interested in linguistic products such as stories and metaphors, which are seen as ways of structuring experience. Third, there is a developmental dimension to the person's capacity to construct their world: we pass through various stages in the process of learning how to interpret the world.

The main historical precursor of constructivist therapy was *personal construct psychology*, originally devised by George Kelly (1955) and later developed by Don Bannister, Fay Fransella, Miller Mair, and their colleagues, largely in Britain (Bannister and Fransella 1985; Fransella 2005). This theory proposes that people make sense of, or 'construe', the world through systems of personal constructs. A typical example of a personal construct might be 'friendly–unfriendly'. Such a construct enables the person to differentiate between people who are perceived as 'friendly' and those who are 'unfriendly'. This construct will function to channel the person's behaviour; they will behave differently towards someone construed as 'friendly' versus someone who is viewed as 'unfriendly'. A construct is embedded within a system. In some circumstances, the 'friendly–unfriendly' construct would be subsumed under a core construct such as 'reliable–unreliable'. Each construct also has its own range of convenience. For instance, 'friendly–unfriendly' can be used to construe people, but not (presumably) food.

Kelly and his colleagues devised a technique known as the repertory grid to assess the unique structure and content of the construct systems of individuals, and also devised a number of methods for applying personal construct principles in therapeutic practice. The best known of the techniques is *fixed role* therapy. Clients are asked to describe themselves as they are, and then to create an alternative role description based on a different set of constructs. They are then encouraged to act out this role for set periods of time. More detailed accounts of personal construct therapy can be found in Fransella (2005) and Fransella et al. (2007).

One of the unusual aspects of personal construct psychology was that Kelly published his ideas as a formal theory, with postulates and corollaries. Later writers and theorists have gradually moved away from Kelly's formal system. Examples of how Kelly's ideas and insights have shaped contemporary approaches to constructivist therapy include Chiari and Nuzzo (2010) and Mair (2012).

A particularly clear statement of the theory and practice of constructivist therapy can be found in the writings of Michael Mahoney, particularly his book *Constructive Psychotherapy* (Mahoney 2003). His approach is based on the application of a set of key principles:

- the creation of a caring, compassionate relationship;
- a collaborative style, in which client and therapist work together to identify strategies for change;
- an action orientation that prioritises what clients are 'actually doing in their lives';
- a focus on the ways in which the person actively makes meaning, and creates order, out of the events of their life;
- attention to the processes of development through which meaning systems are constructed;
- sensitivity to cycles of experience that are involved in active meaning-making: opening/closing; comforting/challenging – productive therapy requires the occurrence of each pole of these cycles.

In practice, Mahoney's constructivist therapy is organised around the use of a very wide range of techniques. Some of these, such as relaxation skills training, problem-solving, cognitive

restructuring, and homework assignments, are based in Mahoney's own initial training and experience in behaviour therapy and CBT. Other techniques, such as reading and writing assignments, personal rituals, breathing and body exercises, voice work and dramatic re-enactment of problem scenarios, are borrowed from many therapeutic traditions. The assumption is, however, not that the technique matters in itself, but that it creates an opportunity for the person to reflect on how they construct the world or reality within which they live, and opens up possibilities for constructing that world in fresh ways.

An example of constructivist therapy in action is the use of *mirror time*. Mahoney (2003) describes how one of his clients had a strong emotional reaction to catching sight of himself in a mirror in the therapy room. This experience stimulated Mahoney to experiment, on himself and with colleagues, with the use of mirrors in therapy sessions, and eventually to develop a protocol for this technique (Mahoney 2003: 251–252). The decision to work with a mirror is jointly taken by the therapist and client together, and the client has a choice of the size of mirror to be used. In advance of looking into the mirror, the client is invited to become centred, and open to their present experiencing, through a breathing and meditation routine. The timing of the mirror activity is organised to allow time to reflect on the experience before the end of the session. Mahoney describes the impact of mirror work on a client named Adam, who had presented with multiple problems. As Adam gazed at his reflection in the mirror, he saw himself in a new way, as someone likeable. This moment, in which he re-constructed his sense of self, did not facilitate significant change in itself for this client, but it did mark a turning point in terms of his pattern of relating to himself, by allowing new meanings and possibilities to emerge.

The version of constructivist therapy developed by Mahoney reflects his own intellectual, professional, and personal journey. In a similar fashion, other constructivist therapists have evolved their own style of working with clients. It is not possible to specify a set of core procedures or techniques that all constructivist counsellors and psychotherapists would use. In this respect, it is quite different from the cognitive-behavioural approach, which possesses a toolkit of familiar techniques with known effectiveness. By contrast, constructivist therapy is principle-driven rather than technique-driven.

### Box 14.1: The use of metaphor in constructivist therapy for PTSD

Therapists operating from a constructivist perspective are interested in *meaning*, and in the ways that people create or find meaning in their lives. When a client talks about events that were traumatic and emotionally painful, it is usually very difficult for them to find the words to capture just how they felt, or what happened. To convey to their counsellor or therapist some sense of the meaning of the event, the client will often use *metaphors*. Unable to articulate what happened directly, a metaphor at least makes it possible to say what the event was *like*. Attention to metaphor is an important theme in constructivist therapy.

In his guide to therapy with people suffering from PTSD, Meichenbaum (1994) places great emphasis on sensitivity to the role of metaphor and he gives long lists of metaphors used by PTSD clients to express their experience: 'I am a time bomb, ready to explode'; 'I walk a thin red line'; 'over the edge'; 'enclosed in a steel ball'; 'a spectator to life'; 'hole in my life'; 'my life is in a holding pattern'; 'prisoner of the past and occasionally on parole'; 'vacuum in my history'. Healing metaphors include:

- Someone who has experienced a traumatic event is like someone who *emigrates* to a new land and must build a new life within a new culture from the one left behind.

- When a flood occurs, the water does not continue forever. There is a rush, but it is temporary and eventually the storm stops, the land dries up, and everything begins to return to normal. Emotions can be viewed in the same way.
- Just as you can't force a physical wound to heal quickly, you can't force a psychological wound to heal either.

Guidelines for the intentional, therapist-facilitated use of metaphor in constructivist therapy can be found in Kopp (2013), Kopp and Craw (1998), and Mahoney (2003).

### Box 14.2: Constructivist counselling for loss and bereavement

Work with clients who are experiencing difficulties around loss and bereavement represents an area of therapy practice that has received a lot of attention from constructivist theorists and researchers. A person who has undergone significant loss needs to engage in a process of re-constructing their sense of self, their relationships, and the stories that they tell about who they are. The American constructivist therapist Robert Neimeyer has made a major contribution to this area (Neimeyer 2002, 2006a, 2006b; Neimeyer et al. 2002, 2006). In particular, his edited collection of papers on techniques of grief therapy provides a powerful example of the value of a constructivist approach in this area of therapy practice (Neimeyer 2012).

### Box 14.3: The emergence of meaning-making as a core therapeutic task

On the whole, mainstream approaches to therapy such as psychodynamic and CBT focus on therapeutic tasks associated with the goal of overcoming dysfunctional emotions, thoughts, and relationship patterns that prevent the client from having a satisfying and productive life. As a consequence of the growing influence of constructivist and existential approaches to therapy, the task of finding meaning in life has gained greater prominence as an issue in therapy. If a person cannot find meaning in their everyday activities, they are likely to feel empty and depressed. Issues around meaningfulness are also evoked by life choices, such as career decisions, as well as in response to life transitions and crises. While clients tend not to highlight loss of meaning as a primary concern, it does comprise a significant dimension within many different types of presenting problem (Hill 2017). A useful guide to therapeutic strategies for exploring meaning in life issues can be found in Hill (2018).

## Solution-focused therapy

Solution-focused brief therapy is mainly associated with the work of Steve de Shazer (1940–2005) at the Brief Family Therapy Center in Milwaukee, and a group of colleagues and collaborators, including Insoo Kim Berg (Berg and Kelly 2000; Miller and Berg 1995), Yvonne Dolan (1991), and Bill O'Hanlon (O'Hanlon and Weiner-Davis 1989; Rowan and O'Hanlon 1999). De Shazer was strongly

influenced by the theory and research carried out at the Mental Research Institute (MRI) in Palo Alto, California. The Palo Alto group were the first, during the 1950s, to study interaction patterns in families, and their approach borrowed heavily from anthropological and sociological ideas as opposed to a psychiatric perspective. De Shazer acquired from his exposure to the ideas of the Palo Alto group a number of core therapeutic principles found in systemic family therapy: a belief that intervention can be brief and 'strategic'; an appreciation of the use of questioning to invite clients to consider alternative courses of action; and the use of an 'observing team', which advises the therapist during 'time-out' interludes. Like many other family therapists (including members of the Palo Alto group), de Shazer became fascinated by the unique approach to therapy developed by Milton H. Erickson. The case studies published by Erickson convinced de Shazer that it was possible to work strategically and briefly with individual clients, not just with families, and that for each client there could exist a unique 'solution' to their own unique difficulties.

In a series of classic texts, de Shazer (1985, 1988, 1991, 1994) developed a distinctive approach to therapy that emphasised the role of language in constructing personal reality. In working out the implications of placing language ('words', 'talk') at the heart of therapy, de Shazer made use of the ideas of philosophers such as Wittgenstein and Lyotard, and the French psychoanalytic thinker Jacques Lacan. The essence of de Shazer's approach to therapy concentrates on the idea that 'problem talk' perpetuates the 'problem', maintains the centrality of the problem in the life and relationships of the person, and distracts attention from any 'solutions' or 'exceptions' to the problem that the person might generate. The task of the therapist, therefore, is to invite the client to engage in 'solution' talk, while respectfully accepting (but not encouraging) the client's wish to talk about their distress and hopelessness, or the general awfulness of their problem. From de Shazer's point of view, therefore, solution-focused sessions are best thought of as conversations involving language games that are focused on three interrelated activities: producing exceptions to the problem, imagining and describing new lives for clients, and 'confirming' that change is occurring in their lives.

### Box 14.4: The contribution of Milton Erickson

Milton H. Erickson MD (1902–1980) was an intriguing figure who played a significant role in the history of psychotherapy. Although originally best known for his use of hypnosis, it became clear to Erickson that the effectiveness of his approach to therapy did not rely on the use of suggestions made to patients while in trance states, but to his sensitive and creative use of language, metaphor, and stories, his capacity to observe the fine detail of the client's behaviour, and his ability to form a collaborative relationship with his clients. Erickson's methods were popularised by the family therapist Jay Haley (1973) and influenced many constructivist therapists (Hoyt 1994), as well as the solution-focused approach of Steve de Shazer.

The solution-focused approach to therapy is built on a number of strategies designed to enable the client to articulate and act on the widest possible range of solutions to their problems. These strategies include the following:

*Focusing on change.* The idea that change is happening all the time is an important concept in solution-focused therapy. Solution-focused therapists assume therefore that change is not only possible but inevitable. In practice, this means that therapists will usually ask new clients about changes in relation to their presenting concerns prior to their first session – often referred to as 'pre-session change'. During therapy, the therapist will usually begin each session by asking the client about changes since the last session – for example, 'What's better even in small ways since last time?'

If the client describes any changes, even apparently minor ones, then the therapist will use a range of follow-up questions to amplify the change and resourcefulness of the client, for instance, 'How did you do that?', 'How did you know that was the right thing to do/best way to handle the situation?' Should the client not be able to identify any change, the therapist might use 'coping questions' to invite the client to talk about how they are managing to survive or cope despite the problem.

*Problem-free talk.* At the beginning of a session, a counsellor might engage the client in talk about everyday activities, as a means of gaining some appreciation of the client's competencies and positive qualities.

*Exception finding.* Fundamental to the solution-focused approach is a belief that no matter how severe or all-pervasive a person's problem may appear, there will be times when it does not occur, or is less debilitating or intrusive in their lives. Such instances again point to clients' strengths and self-healing abilities, which when harnessed allow clients to construct their own unique solutions to their difficulties and concerns. Practitioners will therefore deliberately seek out exceptions by asking clients questions like: 'When was the last time you felt happy/relaxed/loved/confident, etc.?', 'What have you found that helps, even a little?' Exception-finding questions help to deconstruct the client's view of the problem and at the same time highlight and build on the client's success in redefining themselves and their lives.

*Use of pithy slogans.* There are a number of short, memorable statements that help to communicate to clients (and trainee therapists) the basic principles of a solution-focused approach. Typical solution-focused messages include: 'If it isn't broken, don't fix it', 'If it's not working stop doing it', 'If it's working, keep doing it', 'Therapy need not take a long time', 'Small changes can lead to bigger changes'.

*The 'miracle question'.* Typically, in a first session, a solution-focused counsellor will ask the client to imagine a future in which their problem has been resolved: 'Imagine when you go to sleep one night a miracle happens and the problem we've been talking about disappears. As you were asleep, you did not know that a miracle had happened. When you woke up, what would be the first signs for you that a miracle had happened?' (de Shazer 1988). This catalytic question allows the person to consider the problem as a whole, to step into a future that does not include the problem and to explore, with the therapist, how they would know that the problem had gone away, how other people would know, and how such change had been brought about. The image of a 'miracle' is also a potent cultural metaphor that helps the client to remember what they learned from the discussion that follows the asking of the question.

*Scaling.* Scaling questions are designed to facilitate discussion about – and measure – change, and are used to consider a multitude of issues in clients' lives; for instance, to assess a client's readiness or motivation to change, their coping abilities, self-esteem, progress in therapy, and so on. Typically, the client is asked to rate their problem (e.g. depression) on a scale of 0–10, where 0 is as bad as it can be ('rock bottom') and 10 is ideal. Once the client has rated their problem (a 2, for example), the therapist will first enquire about what has helped them to get to a 2 or what the client is doing to prevent slipping back to 'rock bottom'. Subsequently, the therapist will work with the client to negotiate further small goals by inviting them to consider what will be different when they are at 3 on the scale and so on in subsequent sessions until the client reaches a point where they are ready to end therapy.

*Homework tasks – exploring resources.* Towards the end of each session, the therapist will either leave the room to consult with co-workers who have been observing the session, or (if working alone) take a few minutes to reflect in silence. In the final segment of the session, the therapist restates their admiration for positive achievements that the client has made, and then prescribes a



**Table 14.1** Comparison between a problem-focused and a solution-focused approach to therapy

Problem-focused	Solution-focused
How can I help you?	How will you know when therapy has been helpful?
Could you tell me about the problem?	What would you like to change?
Is the problem a symptom of something deeper?	Have we clarified the central issue on which you want to concentrate?
Can you tell me more about the problem?	Can we discover exceptions to the problem?
How are we to understand the problem in the light of the past?	What will the future look like without the problem?
How many sessions will be needed?	Have we achieved enough to end?

Source: O'Connell (2005: 21).

task to be carried out before the next session. The homework task is designed to enable the person to remain focused on solutions. An example of a homework task that might be used following the first session of therapy is: 'Until the next time we meet, I'd like you just to observe what things are happening in your life/family/work that you'd like to see continue, then come back and tell me about it'.

The preceding list covers only some of the many ways in which a solution-focused therapist will structure the therapeutic conversation to allow the client to identify and apply their own personal strengths and competencies. The key points of contrast between a problem-focused and a solution-focused approach to therapy are highlighted in Table 14.1.

The solution-focused approach represents a radical perspective in relation to a number of the key issues that have dominated debates within counselling and psychotherapy during the past 50 years. In psychoanalysis, much of the effectiveness of therapy is attributed to the achievement of suitable insight and understanding of the origins of the presenting problem – for example, its roots in childhood experience. The next generation of therapies that emerged in the mid-twentieth century – humanistic and cognitive-behavioural – retained an interest in understanding the roots of the person's problem, but, compared with psychoanalysis, paid much more attention to what the person might be seeking to be able to do in the future. Solution-focused therapy represents a radical further movement in this direction. In solution-focused therapy, the 'problem' is not particularly interesting. What is important is to focus on the solutions and strengths that the person already possesses, or is able to devise, in relation to living the kind of life they want to live.

The radical shift in solution-focused therapy (and, to some extent, all of the therapy approaches discussed in the present chapter) is a rejection of the notion of the person as being structured in terms of a set of internal mechanisms (mind, unconscious, self, schemas) that have 'gone wrong' and need to be fixed. De Shazer *did not* – and other solution-focused therapists *do not* – view people in these terms. For them, the person exists within the way they talk, within the stories that they tell themselves and other people. From this perspective, any attempt to explore and understand the 'problem' is merely encouraging 'problem talk', the maintenance of relationships characterised by a story-line of the 'I have a problem' type, and the suppression of stories that offer an account of the person as resourceful, capable, in control, and so on. In addition, one of the by-products of an extended exploration of a 'problem' with a therapist is that the person begins to apply the language of psychology and psychotherapy not only as a means of accounting for this specific problem, but as a way of talking about other aspects of their life: the person becomes socialised into a 'problem-sensitive' way of talking about themselves. Moreover, solution-focused therapists reject any assumption that there is a necessary cause-and-effect relationship between studying a problem and arriving

at its solution: a solution is a kind of unpredictable 'creative leap'. This way of looking at therapy seriously challenges any notion of the 'scientific' knowability of what happens in therapy. If clients get 'better' by following their own, idiosyncratic solutions, then what role is left for scientific models of dysfunction and change?

A solution-focused approach can be seen as a rigorous attempt to conduct therapy from a post-modern standpoint. The idea that there exist internal psychological structures that determine behaviour is an essentially 'modern' way of making sense of the world. A postmodern sensitivity argues that these theories/structures are no more than another kind of story. They are stories that are associated with the power that professions and institutions have to define individuals as 'cases', as exhibiting 'deficits' (Gergen 1990). Like other postmodern writers, de Shazer adopted a role of challenging and questioning established ideas, with the aim of opening up possibilities for individuals to create their own personal or 'local' truths, rather than become assimilated into any theoretical framework that claims universal truth. A considerable amount of research has been conducted that confirms the effectiveness of solution-focused therapy for a range of presenting issues (Gingerich and Peterson 2013; Kim et al. 2018).

## Dialogical therapy

The terms *collaborative therapy* and *dialogical therapy* have been used to describe an approach to therapy that emphasises the co-constructed nature of the interaction between therapist and client (Anderson and Gehart 2007; Strong 2000). Collaborative therapy draws on social constructionist and postmodern perspectives in stressing the importance of *dialogue* between equal partners to enable conversations to take place within which new meanings can emerge. As Anderson (2007: 41) puts it: 'dialogue allows us to find ways of going on from here'. The attention that is given, within this form of therapy, to careful listening and responding on the part of the therapist is reminiscent of client-centred therapy.

One of the best-known and most widely researched examples of collaborative therapy is the *open dialogue* approach to working with people experiencing severe mental health problems, developed by Jaakko Siekkula and his colleagues in Finland (Haarakangas et al. 2007; Seikkula and Arnkil 2006; Seikkula et al. 2006). When a person, or their family, seeks help for a crisis in which one member is acting in a manner consistent with a diagnosis of schizophrenia, a team of three therapists is convened. Depending on whether the person is hospitalised, or being helped at home, the team members (drawn from a pool of psychiatrists, nurses, psychologists, social workers, and child guidance workers) will represent the helping networks that are most relevant for the person and their family. A first meeting is convened within 24 hours, attended by the person, their family, other key members of their social network, and workers from official agencies involved in the case. There may be daily meetings for the following 10–12 days. The focus of the meetings is on promoting dialogue, on the basis that new understanding is built up in the 'area between' participants (Seikkula et al. 2006). Rather than rush into the formulation of a treatment plan, or the prescription of medication, there is a high degree of tolerance of uncertainty: 'the psychotic hallucinations or delusions of the patient are accepted as one voice among others' (2006: 216). The results of a five-year follow-up of patients who had received help through the open dialogue approach showed that over 80 per cent had returned to an active social life, with no recurrence of psychotic symptoms. These outcomes compare favourably with those obtained in other studies of first-onset psychosis. In addition, the introduction of the open dialogue model was cost-effective, with a 30 per cent reduction in psychiatric services costs over the period when this approach was introduced, arising from the reduced utilisation of inpatient beds.

The factors that appear to be responsible for the success of the open dialogue approach include:

- A social network perspective – key members of the person's social network are invited to participate.
- Flexibility – the therapeutic response is adapted to the specific and changing needs of each case.

- Psychological continuity – the team that is originally convened retains responsibility for integrating the experiences of all participants, for the duration of the process.
- Dialogue and tolerance of uncertainty – these maximise the active involvement of those who are participating, by ensuring that their views and suggestions are taken into account.

As in narrative therapy, open dialogue and other collaborative approaches are built around a strategy of enabling people to tell their stories, and to begin to create new stories that provide scaffolding for different ways of acting. There is also an emphasis on the process of enlisting community resources. A key difference between narrative therapy and collaborative therapy is that while the former specifies a sequence of therapist activities (e.g. externalising the problem) that will lead to ‘re-authoring’, the latter approach is a more open, dialogical process, in which the shape and structure of the therapy may be created anew in each case. The open dialogue approach has significant implications for the therapists who are involved. As Haarakangas et al. (2007: 232) put it, this way of working means that therapists move from being ‘experts’ to becoming ‘dialogicians’ and co-workers who ‘walk together’.



### Case study 14.3: Open dialogue in action – the case of Martti

Sixteen-year-old Martti was attending a vocational college in a different city from his parental home when ‘everything seemed to fall apart’. He became increasingly isolated and irritable, stopped taking care of his hygiene, talked only in a mumble, and made rocking movements. His parents took him to a primary care centre, and he was admitted for one night. An open dialogue team was assembled and daily meetings were held with Martti and his parents. It was decided that he would return home, and all further meetings were held in his parents’ home. At first, Martti said little, and looked up at the sky; his parents cried a lot. His sister returned home to be with him. Medication was considered, but Martti’s parents did not like the idea, so no prescription was made. Gradually, Martti began to be able to sleep at night and to answer questions. After three months, there was a five-week break, at the request of the family. On resumption of weekly meetings, Martti reported that he wanted to return to college. The team members, and his parents, were concerned about this, and after considerable discussion it was agreed that open dialogue meetings would continue at the college, involving the principal of the school, Martti’s closest teacher, and the school nurse. At the five-year follow-up meeting, Martti was in work and coping well with his life. He was considering entering individual psychotherapy to ‘clarify to himself what had happened during his crisis’.

This case, reported in Seikkula et al. (2006), illustrates the way in which a collaborative caring network can be established around a person in crisis, which the person can use to begin to put their life back on track.

## The radical theatre tradition

Some therapists influenced by narrative, social constructionist, and post-structuralist perspectives have forged connections between therapy and the world of theatre. A key figure in this movement has been the Brazilian theatre director Augusto Boal, who in the 1960s developed an approach known as the *theatre of the oppressed* (Boal 1979, 1995). In a theatre of the oppressed event, a group of actors use exercises and games to bring about a sense of involvement in the audience (who are described as ‘spectactors’, to emphasise their active role in the production). The actors then stage brief dramatic enactments of problematic situations that are familiar to the audience. However, the

members of the audience are invited to interrupt the performance at any point, in order to join in and improvise their own solutions.

An example, taken from a family therapy project in a school in Australia, was based on a performance of a situation in which a teenage son tried to tell his father that he was gay (Proctor et al. 2008). The actors portrayed a scenario in which a boy enters his father's study and asks to talk to him. The father is too busy to listen and seems irritated. After a while, the boy loses his temper and storms out. When the audience replayed the scene, they constructed alternative ways in which the scenario might be played out, including ones in which the son was more assertive, or the father responded in a more compassionate fashion. That audience discussion that followed included a great deal of personal sharing about the experience of 'coming out', and more general issues of parent-child relationships.

The practice of the theatre of the oppressed is based on a number of principles. First, the enactment of everyday dilemmas inevitably shifts the focus from an individualised conception of problems to a more social perspective – the problem is seen to occur in the interactions that take place *between* a group of people. Second, a therapeutic process is constructed that is organised around *action* – rather than just talk about an issue, the person or group has an opportunity to act, to try out different ways of responding to situations. Third, the theatre of the oppressed is an approach that maximises the role of *dialogue* – the possibility of change is facilitated by the interplay between different positions that are taken in the drama. Finally, this approach takes it for granted that many problems arise because individuals are oppressed or silenced by the conscious or unconscious actions of others who are more powerful – the theatre environment that is created is designed to allow those who have been silenced to speak and to be heard.

A similar approach is reflected in the *social therapy* model that has been developed by Fred Newman and Lois Holzman at the East Side Institute for Group and Short Term Psychotherapy and the Castillo Theatre in New York, and associated projects such as the *All Stars Talent Show* (Holzman and Mendez 2003). Other forms of theatre-informed therapy include the development of drama therapy (see Chapter 16).

## Conclusions

A great deal of excitement, creativity, and energy surrounds narrative and constructionist approaches to therapy. For many therapists and clients, it is a liberating experience to be given permission to talk and to tell stories. There is a great richness and wisdom in the everyday stories that people tell. Whereas earlier forms of therapy regarded language as primarily a mirror of the inner state of the client, constructionist, narrative, and collaborative approaches have gone beyond this in their appreciation of the ways in which *conversation* occurs between people and has the possibility of bringing new meaning into existence. These contemporary approaches also recognise and make use of the fact that therapeutic conversations do not only (or even mainly) take place between a therapist and a client, but can occur in interactions between family members and other significant persons in the life of the individual who is seeking help. As a result, practitioners have innovatively pushed the scope of participation in such conversations ever wider, and in so doing have been able to bridge the gap that can often occur between the therapy room and the person's everyday life. Finally, the concept of *dialogue* represents a major and distinctive addition to the conceptual vocabulary of therapy. Dialogue extends the concept of the therapeutic relationship by suggesting that it relies on the existence of a two-way, responsive, active engagement of each person with the other. At the present time, because of its conceptual coherence, global reach, and capacity to reach out to new groups of clients, narrative therapy represents the intellectual and practical anchor-point for this set of therapies. However, it is also essential to acknowledge the contribution of other constructivist and postmodern approaches to therapy, which provide ways of working that may be more compatible with the personal style and preferences, and organisational contexts, within which some therapists and clients engage in therapeutic work.



## Topics for reflection and discussion

- 1 What are your favourite fictional stories (novels, fairy stories, plays, etc.)? Why do these stories appeal to you? Are there ways that these stories capture aspects of your own experience of life, or sense of self? How do you use these stories in constructing your own life-story?
- 2 How satisfactory is the narrative therapy idea of 're-authoring' as a means of characterising the outcomes of counselling and psychotherapy? Can you identify therapy outcomes that are not readily understandable as varieties of 're-authoring'? What are the implications of adopting a specific 're-authoring' focus – are there aspects of the therapy process that may be unhelpfully downplayed?
- 3 One of the key themes in all constructivist and constructionist therapies is an emphasis on the *strengths* and accomplishments of the person seeking help, rather than on their deficits or pathology. What are the advantages and disadvantages of this emphasis, for example, when compared with a psychodynamic approach that explicitly seeks to make contact with the broken or disordered aspects of the client's personality?

## Suggested further reading

There are two classic texts related to this area of therapy. *Narrative Means to Therapeutic Ends* (1990) by Michael White and David Epston is essential reading for anyone interested in understanding more about the 'narrative turn' in therapy. *Constructive Psychotherapy* (2003) by Michael Mahoney is a *tour de force* expression of how constructivist philosophical principles can be allied to practical techniques to create an approach to therapy that is compassionate, caring, and highly effective. The best introductions to narrative therapy are *What is Narrative Therapy?* (Morgan 2000) and *Narrative Therapy: Responding to Your Questions* (Russell and Carey 2004). A posthumous collection of previously unpublished papers by Michael White (2011) provides an insight into the political dimension of narrative therapy. The final chapter of Denborough (2018) offers a powerful personal account of the various influences that have shaped the development of narrative therapy. A valuable overview of different strands of collaborative and dialogical therapy was compiled by Harlene Anderson and Diane Gehart (2007): *Collaborative Therapy: Relationships and Conversations that Make a Difference*. For those interested in the nature of current debates around the 'discursive' therapies, Lock and Strong (2012) have assembled a range of cutting-edge contributions.

# Chapter 15

## Working with families

<b>Introduction</b>	<b>229</b>
<b>Understanding human systems</b>	<b>230</b>
<b>Theoretical traditions within family therapy</b>	<b>231</b>
<b>Family therapy techniques</b>	<b>233</b>
Reframing	234
Questioning	234
Using genograms to explore family patterns across generations	234
Enactments	235
Introducing new perspectives: reflecting teams	235
Initiating change in the social ecology of the family	236
Using rituals to create memorable change events	238
Using feedback to promote collaboration and dialogue	238
<b>Conclusions</b>	<b>239</b>
<b>Topics for reflection and discussion</b>	<b>239</b>
<b>Suggested further reading</b>	<b>239</b>

### Introduction

Most counselling and psychotherapy involves working with problems at an individual level, in one-to-one therapy. At the same time, a central aspect of the experience of living in the modern world is that of struggling to exist within a large and complex social system. While counselling and psychotherapy have been developing methods of working with individuals, other branches of biological and social science have been preoccupied with the problem of finding ways to understand the principles by which systems operate. The growth of a *systemic* perspective can be seen in a number of different fields, from the study of organisations through to research into the properties of living, ecological systems. In the field of counselling and psychotherapy, a systemic perspective takes the form of family therapy. The basic assumption underpinning all versions of family therapy is that the distress or maladjusted behaviour of individual family members is best understood as a manifestation of something going wrong within the family as a system – for example, through ineffective



communication between family members or some distortion of the structure or boundaries of the family group.

The main emphasis in family therapy is on the structural and systemic aspects of family life, on what goes on *between* people rather than what takes place *inside* them. In many ways, such an approach does not sit easily with therapists trained to work with self, feelings, and individual responsibility. Nevertheless, the intellectual coherence and effectiveness of family therapy concepts and methods has led to an increasing acknowledgement on the part of many therapists that it is essential to include in their work an awareness of systemic dimensions of the lives of their clients.

Therapeutic work with families is consistent with the beliefs and values of cultural groups and communities in which people define their identity more in terms of family relationships than individual autonomy. Some proponents of a family systems perspective on therapy regard themselves as offering a radical alternative to mainstream individualistic forms of therapy practice, because their style of therapy more effectively aligns itself with political traditions that promote solidarity, connectedness, and social justice.

The present chapter offers an introduction to the key principles and techniques of a family-oriented approach to therapy. The chapter begins with a brief account of some key ideas used in understanding human systems, then discusses how family therapy works in practice.

## Understanding human systems

The analysis of systems of one kind or another has generated a vast literature. However, it seems clear that much systemic thinking originates from the ideas of Ludwig von Bertalanffy, the founder of cybernetics, Norbert Weiner, an information theorist, and Gregory Bateson, a philosopher and anthropologist, mainly formulated in the 1940s and 1950s (Guttman 1981). The key idea is that a system comprises a whole made up of interrelated parts, and that, crucially, change in any one part affects the rest of the system. These processes can be seen to operate in social, biological, and mechanical systems. For example, a motor car is a whole system made up of many subsystems (the brakes, gear box, engine, etc.). If even a minor change happens in one subsystem, such as the tyres being under-inflated, there will be consequences in other areas – in this instance, more strain on the engine leading eventually to breakdown. To take another example, a family can be viewed as a system containing, perhaps, a mother, father, and two children. Each of them plays certain roles and fulfils specific tasks within the system. If, however, the mother becomes seriously ill and is not able to continue to discharge the same roles and tasks, then these functions will be redistributed among other members of the family, changing the balance of relationships.

There is another property of systems that is closely linked to the part-whole idea. Functioning systems tend to be *homeostatic* in the way that they operate. In other words, once a system is established – is ‘up and running’ – it will tend to keep functioning in the same way unless some external event interferes: systems reach a ‘stable state’ in which their parts are in balance. The most common example of homeostasis is the operation of a domestic central heating system. The room thermostat is set at a certain temperature. If the temperature rises above that level, the boiler and radiators will be turned off; if the temperature falls below, the boiler and radiators are switched on. The result is that the room, or house, is maintained at a steady temperature. This process can be understood as one in which feedback information is used to regulate the system (in the case of domestic central heating, the thermostat provides feedback to the boiler). Homeostasis and feedback also occur in human systems. To return to the example of the family in which the mother becomes seriously ill, there are likely to be strong forces within the family acting to prevent change in the system. For instance, the mother may not be physically able to wash and iron clothes but may have a belief that this is what a ‘real mother’ must do. Her children and spouse may share this belief. The sight of the father incompetently ironing the clothes can serve as feedback

that triggers off a renewed effort on her part to be a 'real mother', but then her attempt to do the ironing could make her more ill.

Implicit in homeostasis and feedback is the significance of *difference*. To understand how a system functions, it is necessary to be alert for disturbances, crises, shifts – any manifestations of difference and destabilisation. For a family therapy, evidence of difference (what is different then and now, how various members see things differently, how things look different from the perspective of an outside observer) provides an indication of a starting point for therapeutic inquiry. Family therapists aim to 'put difference to work'.

Another important idea found in general systems theory is the notion that all systems are based on a set of rules. In the example just given, the hypothetical family being described possesses powerful, unwritten rules about gender and parental roles and identities. These rules may function well for the family when it is in a state of equilibrium, but at times of change it may be necessary to revise the rules, to allow the system to achieve a new level of functioning. With this family, it would seem clear that unless they can shift their notion of 'mother', there will be a fundamental breakdown in the system brought about by the mother's hospitalisation.

An additional core concept in systemic approaches relates to the notion of the *life cycle* of a system. To return to the example of the motor car, a vehicle such as this comes supplied with a detailed set of rules concerning when certain parts should be inspected, adjusted, or replaced. Similarly, a human system such as a family tracks its way through a predictable set of transitions: leaving home, marriage, entering the world of work, the birth of a child, the death of a parent, retirement, the death of a spouse, and so on. The issue here is that while some changes to the family system (e.g. illness, unemployment, disaster) are unpredictable, there are many other potential disruptions to the system that are normative and wholly predictable. This realisation brings with it important ways of understanding what is happening in a system, by looking at how it reacts to life-cycle transitions and what it has 'learned' from previous events of this sort.

Another useful aspect of systems theory is the significance of boundaries between different systems, or between subsystems. For example, when two people get married, they initiate a point of contact between two existing systems (the families of each spouse). How that boundary is managed can be crucial to the eventual success of the new family system. For instance, if the husband still looks towards his mother as his primary source of emotional support, it will weaken the emotional bonds and cohesiveness of the family system being created with his wife and children.

The systemic ideas presented here represent a simplified version of an enormously complex body of theory. For example, for reasons of space, notions about the ways in which causality operates within systems have not been discussed. Readers interested in learning more about family systems theory are recommended to consult Dallos and Draper (2015) and follow up the sources cited in that text. Nevertheless, it is hoped that these core systemic principles are sufficient to map out the basic outline of a powerful and distinctive style of counselling and psychotherapy.

A systemically oriented therapist is not primarily interested in the intrapsychic inner life of their client. Instead, they choose to focus on the system within which the person lives, and how this system works. Essentially, if a person reports a 'problem', it is redefined by a systemic therapist as a failure of the system to adapt to change. The goal of the systemic therapist, therefore, is to facilitate change at a systemic level – for example, by rewriting implicit rules, shifting the balance between different parts of the system, or improving the effectiveness of how communication/feedback is transmitted. These underlying principles have generated a wide range of distinctive family therapy theories and interventions.

## Theoretical traditions within family therapy

A systemic perspective has been articulated in therapy in a variety of different ways by different groups of family therapists, resulting in a number of separate schools of family therapy, each of which has generated its own body of theory and research, style of practice, and training institutes.

*Structural* family therapy was created by Salvador Minuchin (1974) and his colleagues in Philadelphia. The key concepts employed within this model to understand the structure and patterning of interaction in a family are subsystems, boundaries, hierarchies, and alliances. The *strategic* approach to family therapy grew out of pioneering research carried out by Gregory Bateson, John Weakland, Don Jackson, and Jay Haley at the Mental Research Institute in Palo Alto, California, in the 1950s. Haley later became the central figure in this approach, and introduced some of the ideas of the hypnotherapist Milton Erickson. The distinctive features of this model are the use of techniques such as paradoxical injunction, reframing, and the prescription of tasks to bring about change in symptoms.

The *Milan* group, featuring Mara Selvini Palazzoli and her colleagues (1978), emphasised the collective construction of a family reality through shared beliefs, myths, and assumptions. The Milan-systemic school makes particular use of the idea of circularity, which refers to an assumption of reciprocal causality: everything causes and is caused by everything else. All parts of the family system are reciprocally connected, and the therapy team will attempt to open up this aspect of family life through circular questioning. For example, rather than ask a family member what he feels about something that has happened in the family, the therapist could ask how he feels about what his brother thinks about it, thus both introducing an awareness of the links between people and raising the possibility of generating multiple descriptions (double descriptions) of the same event. Other techniques introduced by the Milan school include positive connotation (giving a positive meaning to all behaviour – for instance, ‘how brave you were to withdraw from that situation to preserve your commitment to the family’s core values . . .’) and the use of therapeutic ritual.

Out of these foundational approaches to family therapy have emerged developments in theory and practice that have focused on the type of conversations that occur in families, and how the reality of family life, and patterns of relationship, are constructed and negotiated through storytelling and metaphor. This kind of perspective is reflected in the narrative therapy approach to family therapy (Dickerson 2016; White and Epston 1990) and the idea of family therapy as dialogue developed by Peter Rober (2017) and his colleagues.

Some models of family therapy reflect the influence of psychoanalytic and psychodynamic thinking. The model developed by Murray Bowen pays particular attention to tensions and conflicts associated with triangular or three-way relationships (e.g. the husband, wife, and new baby), an idea that is widely used in psychodynamic therapy (Bowen 1978). Another key feature of the Bowen model is the concept of differentiation of self. Family members can be enmeshed with others and unable to think for themselves (undifferentiated), or they may have been able to establish some distance between themselves and other family members, thereby allowing them to have a more autonomous or differentiated sense of identity. Research into this phenomenon has found that people who are more differentiated are better able to cope with situations that might trigger anxiety or depression, because they have more options. Another psychodynamically informed approach is attachment-based family therapy (Diamond 2014). This perspective works with the implications of insecure attachment relationships between members of a family. It does not do this by following the route pioneered by individual dynamic therapists, of interpreting attachment patterns in the relationship between client and therapist, or exploring the early experience of the client. Instead, attachment-based family therapists argue that attachment issues are expressed through emotion, and so are interested in the expression of emotion in a family and how emotions are handled.

Various formats are used by therapists who apply these models in their work with families. Most family therapists prefer to work with the whole family, or key members of a family, in sessions where all participants meet together. Other therapists who are informed by systematic ideas may work primarily with an individual member of a family, such as a child who has problems or an adult member who has had a psychotic breakdown, and bring in other members of the family to support the main client. The common element across these formats is that of working with one family at a time. An important innovation in family therapy, known as multi-family therapy, involves working with as many as eight families at a time, in a series of whole-day workshops or a residential event that might last for a week (Asen and Scholz 2010; Dare and Eisler 2000). This strategy makes it

possible for families to support each other, and to learn through observing the ways in which other families handle issues in either constructive or unhelpful ways. It also allows for a different type of relationship between family members and therapists. What seems to happen is that the therapists facilitate and manage meetings, and initiate teaching inputs and exercises, but it is the participants who do the work of processing issues through their interactions with each other (Engman-Bredvik et al. 2016; van Ee et al. 2018).

These are just some of the most widely used models of family therapy – it is a field that is characterised by a high degree of innovation, with new ideas entering circulation on a regular basis. In recent years, the divisions between major schools of family therapy have gradually dissolved as increasing numbers of therapists have integrated different approaches within their own practice, or teams of family therapists in particular clinics or services have pooled their knowledge and experience to create a local model of practice that meets the needs of the particular client groups that they see (Smith et al. 2017). However, without wishing to deny important differences between the established approaches, it is possible to see significant points of convergence in the way that they have been put into action. Omer (1994) has argued that the differences between family therapy practitioners are more matters of style than of substance.

The common ground of contemporary family therapy can be taken to include:

- the active participation of all or most family members, to allow patterns of interaction to be observed and change to be shared;
- interventions aimed at properties of the system rather than at aspects of the experiences of individuals: the therapist works with the family system as a whole;
- the therapist adopting a detached, neutral stance, to avoid joining or being ‘sucked in’ to the system or seduced into forming an alliance with particular family members or subgroups;
- therapists working as a team to give them a better chance of detecting subtle interaction patterns that occur in the complex dynamic of a family’s way of being together;
- the use of a limited number of high-impact sessions as a means of intentionally disrupting the family system, rather than a longer series of more supportive sessions.

Many of these approaches to family therapy have their origins in work with schizophrenic/psychotic patients and their families, and with clients suffering from anorexia. It is generally accepted that therapy on a one-to-one basis with such clients is highly demanding. To enter the inner world of such a client, to be empathic over an extended period of time, may bring a therapist into close contact with feelings of terror, engulfment, overwhelming threat, destructive ways of thinking, helplessness, and despair. It is hardly surprising, then, that the most effective types of therapeutic intervention for clients with these issues (and other severe problems) have been family therapy and therapeutic communities. In the early years of family therapy, the emotional demands of working with such clients resulted in the development of a style of doing therapy that, to a large extent, functioned to insulate the therapist from direct person-to-person contact. This aspect of family therapy practice has changed substantially in recent years, under the influence of writers such as Bott (1994), O’Leary (2011), and Reimers and Treacher (1995), who have argued for a more collaborative and person-centred stance. There have also been research studies, and associated training initiatives, that have explored the inner experience of family therapists during their work with families (Frediani and Rober 2016; Rober 2011; Rober et al. 2008). This research has supported family therapists in becoming more emotionally available to their clients.

## Family therapy techniques

The task of doing therapy with a family differs in significant ways from that of working with an individual. Rather than being able to engage directly with a particular person, a family therapist tries to

engage with a number of people at the same time. In addition, a family therapist tries to make sense of, and instigate, change in relation to how these people interact with one another. What happens in family therapy is therefore not only more complex than in individual therapy, it is also trying to accomplish different things. The following sections offer an introduction to some widely used family therapy techniques. It is important to appreciate that these distinctive systemic interventions build on universal therapist skills and qualities such as being warm, accepting, empathic, using open questions, self-disclosure, and exploration of meaning. In their analysis of strategies used by family therapists in early sessions, Nichols and Tafuri (2013) found that their participants made more use of supportive and empathic responses at the start, along with explaining to clients how therapy worked, then moved into a more active and interventionist mode once rapport and a sense of alliance had been established.

## Reframing

A common strategy in family therapy is to offer a family member, or the family as a whole, an alternative way of making sense of something that is happening in the family. Reframing has two main strategic purposes: positioning family members to be able to control their actions, and as having strengths. The aim is to invite family members to talk about their experiences in a way that allows more possibilities for change, and to replace a 'blame' culture with a more hopeful way of being. For example, a member of a family may describe himself as 'always depressed', or be described in such terms by other family members. Following exploration of what this depression looks like, the therapist might say that the depressed person is 'unwilling to burden other people in the family with these his deep sadness about the loss of his grandfather, so has chosen to keep these feelings to himself', or is 'feeling isolated and scared at his new school, and struggling to cope with the bullying he has undergone, but believes that everyone else has a lot on their plates as well, so believes that he should deal with it on his own'.

## Questioning

All therapists use questions – to invite a client to explore an issue in more detail (open-ended questions) or to clarify a particular point (informational questions). Although family therapists use these kinds of questions, they also deploy a more purposeful and specific style of questioning that has the strategic purpose of being able to learn about how family members interact with each other, and also helping members to become more aware of such patterns (Brown 1997). This style of questioning is sometimes described as 'circular' (Penn 1982). For example, the mother may talk about being away from home a lot because of long work shifts as a nurse. The therapist may turn to another member of the family and ask, 'What did you think and feel when mother talked about being away?', or ask the family as a whole, 'Who misses mother the most? Who misses her the least?' These questions provide evidence of how mother's actions influence others. Once someone has replied, the therapist might then ask the mother how she reacted to that response. A question such as 'What does working long hours say about what is most important in life?' opens up links between underlying beliefs and values and the actual behaviour of family members.

## Using genograms to explore family patterns across generations

A family systems perspective entails an interest in intergenerational or transgenerational influences. For example, the occurrence of mental health problems, partner violence, or alcoholism in a previous generation (parents or grandparents) might have a major influence on how someone might view these problems within their present family system. A woman whose grandfather was a violent alcoholic might react very strongly to a teenage son coming home drunk, whereas a woman without such an intergenerational legacy might treat the same event in a more rational and balanced manner. Secrets represent another important source of intergenerational influence. If the husband does not



know that his wife's grandfather was a violent alcoholic, he might be confused about her strong reaction to the drunk son.

In practice, it is hard to keep track of intergenerational influence. A technique that is widely used in family therapy to depict intergenerational patterns of relationships is the genogram. This is similar to a family tree or family history. Usually, the information is gathered by the therapist in an interview and a chart or diagram is co-constructed by therapist and family members. It is also possible to give clients instructions on how to complete a self-administered genogram. Genograms employ a set of conventional symbols – for example, a man is represented by a square and a woman by a circle. A close relationship is designated by a double line between individuals, and a conflictual relationship by a jagged line. Information regarding the process of constructing a genogram can be found in McGoldrick et al. (2008) and Papadopoulos et al. (1997).

A genogram is used to map how a problem may have evolved over time, or be linked to family dynamics. The genogram can also help in highlighting events that have been significant for the family. A genogram is not only a method for gathering information, but also an intervention in itself, because participating in the construction of a genogram may well enable family members to achieve greater understanding of the role they play in the family, and the roles played by other family members.

Since its initial development, the basic idea of a genogram has been taken in many different directions, including making use of perspectives from psychodynamic therapy (Browning and Hull 2018), trauma theory (Goodman 2013), and the Bowen model (Gatfield 2017). Fiaschini (2017) has devised a workshop approach to exploring the meaning of a genogram, and Jedlicka (2011) has created an alternative framework for mapping family histories known as 'affinographs'. These examples of innovation reflect the extent to which family therapists have incorporated the genogram into their practice and made it their own.

## Enactments

The technique of enactment refers to an invitation by the therapist for family members to interact with each other (Nichols and Fellenberg 2000; Woolley et al. 2012). This allows the therapist to observe at first hand how they respond to each other (rather than needing to rely on their reports of what happened in the past). It also allows family members to reflect on the ways of interacting that are exhibited. It is a way for everyone in the family to be involved, rather than the process being dominated by one or two individuals. Finally, it opens up possibilities of imagining and trying out different ways of interacting.

Enactment can be as simple as asking the family to talk together about a decision that faces them (e.g. 'who is going to visit Granny next Sunday') or re-enact an episode that has already taken place ('can you show me what happens when you all sit down to dinner'). A more complex form of enactment is to construct a family sculpture. This is an exercise through which one family member arranges the other people in the family to represent the way that they see the family. The position of the people in the family, their facial expressions and posture, closeness or distance, and direction of gaze all convey the sculptor's sense of what the family is like from their perspective. Sometimes, the therapist might ask the person to re-sculpt the family in terms of how they would ideally like it to function or how they imagine it might be in the future, or might invite other family members to create alternative sculptures.

## Introducing new perspectives: reflecting teams

When a family takes part in therapy, as a group, there is a lot happening – a multiplicity of interactions between individuals and within subgroups. It can be very hard for a therapist, or even a pair of therapists, to keep track of what is going on. In the early years of family therapy, additional members of the therapy team would sit behind a one-way mirror, or watch the session on live video feed, and provide feedback and guidance for the primary therapists in the room. A Norwegian psychiatrist, Tom Andersen, developed the idea of the 'reflecting team': a group of therapists or trainees





### Case study 15.1: Using family sculpting

Onnis et al. (1994) provide an example of the use of sculpting with a family that had been referred because Gianni, aged ten, suffered from severe chronic asthma, which had shown little improvement in response to standard medical procedures and had been diagnosed as 'untreatable'. The family comprised Gianni, his mother and father, and a 7-year-old younger sister, Sabrina. Asked to sculpt his family 'as it was presently', Gianni placed an empty chair between his parents, and situated his sister in front of his mother, looking at her. He placed himself in front of the other members of the family, facing the empty chair. After completing the sculpture, he quickly ran to sit down in the empty chair between his parents. Gianni was then asked to represent the family as he thought it would be in ten years. He placed his sister at a distance, facing away from them. He said that she was facing 'towards a friend'. He then placed himself in front of his parents, with himself as the apex of a triangle, at the centre of their attention. He announced that 'they are looking at me'. The therapist asked Gianni where he was looking, and he replied: 'I'm looking at the mirror' (the one-way mirror on the wall in the therapy room). His parents interjected that they did not have a mirror like that at home, and Gianni turned to his parents and said, 'I'm looking at them. They're looking at me, and I am looking at them, like three pillars!' He then began to cough as he was about to have an asthma attack.

These sculptures were interpreted by the family therapy team as expressing, first of all, Gianni's feeling that there was 'a distance between Mom and Dad', and that he had to capture his father's attention and check that he stayed in position. Gianni saw his role in relation to his parents as 'neither of the two will leave if I am between them'. The therapy team understood the second sculpture as representing Gianni's fear of change. Based on these messages, the therapy team offered the family a reframing of their situation that suggested some possibilities for positive change. These included the idea Gianni was carrying a massive burden that could 'suffocate' him and 'take his breath away', and that some parental reassurance that he did not need to carry responsibility for the future of the family as a unit might help him to breathe more easily. Central to this formulation was the characteristic family therapy strategy of positive connotation/reframing of the symptom. The asthmatic attacks were characterised not as a problem, but as a positive sacrifice that Gianni was making in order to preserve the family unit. In this case, the family was well able to develop the alternative strategy (the parents taking up the burden) implied in the reframing statement, and soon Gianni's asthmatic crises reduced considerably.

who watch the session (now usually from within the therapy room) and share their reflections in the presence of the family. The family is not a part of the conversation with the reflecting team, but merely listens. This technique continues to allow a more comprehensive appreciation of family interaction patterns, while at the same time creating an opportunity for family members to reflect on a range of different perceptions on what has been happening. It is also valuable that these perceptions are 'de-centred' – they are not associated with the authority of the primary therapists, and so family members are better able to accept or reject them as they see fit. The use of a reflecting team has been adapted and modified by different groups of family therapists, as well as by therapists working within the narrative therapy tradition. Examples of different ways of organising the reflecting team process can be found in Friedman (1995) and in family therapy textbooks.

### Initiating change in the social ecology of the family

As an entity in itself, a family is connected to, and shares boundaries with, the community and society within which it exists. One way of making sense of this within family therapy is to adopt an ecological approach, and to explore the social ecology within which a client or family lives their life.



### Case study 15.2: A young man experiencing panic attacks

Willi et al. (2000) analysed the case of a 29-year-old man who experienced frightening panic attacks, even when asleep. In his childhood and adolescence, the client had been exposed to insecurity in his relationships with his mother and father. As a result, on entering adult life he developed a niche for himself as an 'independent adventurer', through work as a sailor or odd-job man who had numerous affairs. He was generally admired by his friends in this role, and the niche he had created for himself allowed him to avoid the possibility of hurt through becoming attached to another person.

In therapy, he became aware that his panic attacks had started when he had entered a relationship with a new girlfriend, who was very devoted and affectionate towards him. He had moved in with her. Most of his friends by this time had 'settled down' and started families, and they expected him to do likewise. Over the course of therapy, he came to understand that his old niche was no longer fully appropriate for him – he wished to sustain a more settled relationship. At the same time, his persistent need for independence made living with his girlfriend intolerable. He was able to develop a new niche, which encompassed some of the features of his 'early adult' way of life, but which also enabled him to continue his relationship with his girlfriend on a more distanced basis.

The *ecological* approach to therapy, pioneered in Switzerland by Jurg Willi and his colleagues (Willi 1999; Willi et al. 2000), suggests that the individual shapes their environment into a personal *niche* that allows them to meet their emotional and interpersonal needs. However, a niche that may have been highly functional at an early stage in a person's life (for example, as a young adult) may become dysfunctional as the individual develops as a person and acquires different motives or needs.

The ecological framework devised by Willi (1999) proposes that a person necessarily exists within a social system, and that constructive change involves taking into account what is happening in the system as a whole. Ultimately, it is a perspective that invites the individual to create (and re-create) their niche.

The social ecology of many families is more challenging than in the case described by Willi et al. (2000). These families struggle to cope with an external environment that may involve racism, criminality, poor housing, or many other sources of adversity. These aspects of their niche may be represented by specific institutions such as a school, welfare office, and landlord. An important strand of contemporary family therapy involves working with families to empower them in their engagements with these agencies (St. George and Wulff 2016). The narrative therapy approach places a particularly strong emphasis on this kind of social justice dimension of family therapy (see Chapters 14 and 26).



### Case study 15.3: Using ritual in therapy

Imber-Black and Roberts (1992) describe the case of Brian, aged 19, who went to live with his older brother when his mother died. This was a difficult time for Brian, who told his brother and sister-in-law that 'I feel I don't have a security blanket'. After reflecting on this statement, the older brother and his wife got together with other surviving members of the extended family to create a patchwork quilt for Brian, using pieces of his mother's nurse uniform, his father's marine shirt, and other fabric that carried meaning for Brian. They presented the quilt to Brian on the

occasion of his grandmother's 80th birthday. It symbolised for Brian, and the family as a whole, that his brother and sister-in-law were able to give Brian the nurturing and 'security blanket' that he needed. This family ritual gave members of the family a structure through which to channel their concern for Brian, it brought them all together in a collective expression of grief and hope, and, finally, it made use of a tangible physical object, a quilt, that could function as a symbol and reminder of what they had done and felt. Other physical symbols used in family rituals can include candles, places where objects or messages are buried, and boxes that contain worries or joys. Further discussion and examples of rituals in family therapy can be found in Nelson and Trepper (2014).

## Using rituals to create memorable change events

A key feature of families and other social systems is the use of ritual to mark the transition from one social role or status to another, to symbolise the bonds between group members, and to express the relationship between individuals and a higher power. The family life cycle is marked by a series of rituals – marriages, Christmas or Thanksgiving celebrations, funerals. In a modern, largely secular world, many traditional rituals have lost their meaning, or may be inappropriate where families comprise people from different religious or ethnic backgrounds. Some therapists have suggested that it is important for people to be able to invent their own rituals (Cole 2003; Imber-Black and Roberts 1992). Family therapists have become interested in the ways that ritual occasions, such as mealtimes, exemplify the values and relationship patterns of a family, and have also developed ways of employing ritual to facilitate change in families (Wyrostok 1995). A particularly important use of ritual is around facilitating the rite of passage between one social status, or stage of the life course, and the next (Beels 2007).

## Using feedback to promote collaboration and dialogue

As with other areas of counselling and psychotherapy practice, there have been important developments in family therapy in recent years in the use of brief outcome and process measures as ways of keeping track of the progress of therapy, providing feedback for the client and therapist, and facilitating collaboration. The situation is more complex in family therapy, compared to one-to-one therapy, because feedback needs to be collected from more than one person, and there may be power and literacy imbalances between clients (i.e. parents and children) (Tilden and Wampold 2017). There has been extensive use by family therapists of the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) (Miller et al. 2016), which are measures primarily developed for use in individual therapy (including child-friendly versions). Measures specifically developed for use in family therapy include the Systemic Clinical Outcome and Routine Evaluation (SCORE) scale (Cahill et al. 2010) and the Systemic Therapy Inventory of Change (Pinsof et al. 2015). In addition, Rober et al. (2016) have developed the Dialogical Feedback Tool (DFT), a qualitative feedback tool for use in family therapy and intended to be relevant for both child and adult clients. The form comprises a single page, with two faces (one smiley, the other unhappy) linked to thought bubbles. The client is asked to write within each bubble, what they think about the session today.

Research into the experience of family therapy clients using the SRS and ORS to give feedback to their therapists has been undertaken by Sundet (2014). He found that clients understood, appreciated, and supported the use of these tools, and reported that the conversations that followed completion of the scales were helpful in identifying a focus for therapeutic work and in deepening therapist and client understanding and exploration of key issues. By contrast, McComb et al. (2019), in interviews with family therapy trainees and their supervisors, found that they identified a number of problems arising from use of feedback tools, including time demands.

## Conclusions

Systemic approaches to therapy view the person as fundamentally a *relational* being, existing as part of a family, group, or community. The various approaches to family and systemic therapy discussed in this chapter have taken up the challenge of implementing a relational approach to therapy that respects the significance of family experience and family bonds. A considerable amount of both qualitative and quantitative research has been conducted into family therapy, providing convincing evidence of the effectiveness of this approach (Heatherington et al. 2015; Medway and Rhodes 2016).



### Topics for reflection and discussion

- 1 Reflect on your own experience in relation to the family in which you grew up. To what extent, and in what ways, have the ideas presented in this chapter helped you to make sense of that experience?
- 2 What ethical issues might arise when working with a family? How might confidentiality and informed consent operate within a system? Is the ethical principle of respect for autonomy still relevant?
- 3 Reflect on the implications for the client–therapist relationship of adopting a systemic perspective. For example, from a person-centred perspective, a good relationship would be characterised by high levels of congruence, empathy, and acceptance. Are these concepts applicable in systemic work? How relevant are psychoanalytic ideas of transference and countertransference?
- 4 Are there particular personal issues and difficulties that might be more suited to a systemic or family-centred approach to therapy, and other issues that might be better dealt with at an individual level?
- 5 What is your own personal ‘niche’? How have you negotiated change in your niche, as your needs and desires have changed at different points over the course of your life?

## Suggested further reading

An accessible and sensitively written introduction to family therapy is *In Therapy Together: Family Therapy as a Dialogue* (Rober 2017). Well-established textbooks that contain a wealth of relevant material on systemic approaches to counselling and psychotherapy are *An Introduction to Family Therapy* (Dallos and Draper 2015) and *Family Therapy: Concepts, Process and Practice* (Carr 2012). Practical, down-to-earth accounts of the main skills and techniques used in family therapy can be found in *Family Therapy: 100 Key Points and Techniques* (Rivett and Street 2009), *Family Therapy Skills and Techniques in Action* (Rivett and Buchmüller 2017), and *101 Interventions in Family Therapy* (Nelson and Trepper 2014). Both of the main research and professional journals in this field, *Family Process* and the *Journal of Family Therapy*, consistently publish papers that are stimulating and readable.

# Chapter 16

## The use of art in therapy

<b>Introduction</b>	<b>240</b>
<b>The therapeutic use of art: forms of practice</b>	<b>241</b>
Drawing, painting, and sculpting	242
Photography	243
Writing	243
Music	245
Drama	246
Other ways of using art in therapy	246
<b>Therapeutic processes associated with the use of art in therapy</b>	<b>247</b>
<b>Art as a way of making sense of therapy</b>	<b>249</b>
<b>Art as a means of communicating the findings of research</b>	<b>249</b>
<b>Conclusions</b>	<b>250</b>
<b>Topics for reflection and discussion</b>	<b>250</b>
<b>Suggested further reading</b>	<b>251</b>

### Introduction

Art can be understood as the making of objects and performances that are 'special' (Dissanayake 1988, 1992, 2000). Art appears to be an intrinsic aspect of what it means to be human, and is a mode of expression and communication that is used throughout the world to symbolise the core values of a culture. There is a long tradition of the use of art as a method of dealing with problems in living. Scheff (1980) described the role that dramatic performance played in ancient Greek culture, as a method of enabling the healing of emotional wounds. Hogan (2001) documents the important role that music, painting, and architecture played in the 'moral treatment' for the insane that developed in England in the early nineteenth century.

During the period in the twentieth century when counselling and psychotherapy became professionally established, a set of arts-based therapies evolved as distinctive forms of practice and with specific areas of application. The main arts therapies to achieve professional status have been art therapy, dance therapy, drama therapy, poetry therapy, and music therapy. These therapy modalities are associated with specialist training programmes. Although they can be used with any clients,

there has been a tendency for them to be used with clients who have difficulties verbally expressing themselves, such as children, individuals with learning difficulties, and people who are traumatised or severely mentally ill (Malchiodi 2004a, 2004b).

Typically, therapists who have received training in art, dance, drama, or music therapy have tended to use only that specific medium in their work with clients. More recently, however, there has been an increasing recognition that 'expressive' and creative methods can usefully be integrated into ordinary 'talk' therapy practice. This broader use of art-based techniques involves the client being offered the opportunity to work with a range of expressive media, depending on their preference and on the specific issue being explored. In addition, specific art-based activities can be used as a one-off adjunct or 'add-on' to therapy with a client. In their everyday lives, people use art-making and art-experiencing (i.e. watching a movie or listening to music) as resources that give meaning to life and as sources of support at times of trouble. The concept of 'outsider art' refers to the exhibiting of art-works made by those without a professional training in art, such as patients in psychiatric hospitals (Peiry and Frank 2006). At a community level, there are many ways in which art has been deployed to support well-being, such as art-works in public spaces and hospitals (Clift and Camic 2016).

The wide range of art-making practices used in therapy include: autobiographical writing, dance and movement, dramatic performance, film, music, painting and drawing, photography, poetry writing, sand tray play, sculpting clay or other materials, storytelling, tapestry, and quilting. Within each of these (and other) art forms, the person can be encouraged to express their feelings, thoughts, sense of identity, and relationships through the process of *making* objects and performances. This can be carried out in simple ways, with little equipment, such as offering a client a piece of paper and some coloured pens and inviting them to make a drawing of what their life is like at the present time. Alternatively, art-works that already exist (such as movies and novels) can be used as templates or triggers for the inner life of the person.

It is beyond the scope of the present chapter to provide a comprehensive review of art therapy (i.e. the use of painting, drawing, and sculpture) or creative arts therapies (i.e. music, drama, poetry, dance). Comprehensive reviews of research and practice in art-based therapy are available in Gussak and Rosal (2015), Rubin (2005), van Lith (2016), and Warren (2008). Instead, the aim here is to explore the relevance for therapy of art as a perspective and way of knowing. The chapter explores some examples of the therapeutic use of art, before moving to consider how and why art-making makes a difference. Throughout the chapter, 'art-making' and 'craft-making' are treated as similar activities, on the basis that the distinction between arts and crafts is culturally specific and of recent historical origin and thus not relevant to therapy.

## The therapeutic use of art: forms of practice

There exist a wide range of traditions and forms of practice in relation to the therapeutic use of art. Most forms of art-making activity can be offered within a typical one-to-one, one-hour therapy session. However, some arts therapy approaches probably work best in group or workshop/group settings (e.g. drama therapy, dance therapy). Arts techniques also differ in respect of their requirement for special facilities and equipment. For example, drawing or writing only requires pens, crayons, and paper that can be made readily available in any office space, while music, sand tray play, and sculpture need more pre-planning.

The following sections introduce the main art-making techniques used in therapy. Within each of these forms of practice can be found a continuum of expertise. It is possible to undertake specialist training in art therapy, drama therapy, and other art approaches, and become part of a professional association or network of therapists who use that technique. However, there are also many counsellors and psychotherapists who use these techniques in the absence of extended specialist training. These practitioners may have learned about art-based therapy during their



basic training or during post-qualification continuing professional development workshops, and use particular art activities as part of their repertoire of therapy methods without considering themselves art therapists.

It is generally the case that therapists use art-based methods that resonate with their own personal interests and life experience, and are able to draw on their basic curiosity around the method to keep them open to new learning.

## Drawing, painting, and sculpting

Using images to express and convey meaning is a cultural universal. Everyone, at some time or another, makes diagrams, doodles, drawings, patterns, or maps. Drawing, painting, and sculpting are developmentally significant, because children learn to use these media before they are able to write. Some well-established therapy approaches, generally informed by a psychoanalytic or psychodynamic perspective, are based specifically around the visual arts, where the client spends much of the time making objects and images and then talking about them in a group or with their therapist (Edwards 2013; Hughes 2016; Schaverien 2009).

However, art-making can be part of almost any therapy. There will almost certainly be pen and paper available in any therapy room. Many therapists also like to have additional art-making materials at hand – coloured pens, chalk and crayons, rolls of paper, jars of buttons, bowls filled with stones or shells, sand trays, pieces of plasticine, and so on. The presence of such materials in the therapy room acts as an invitation to and reminder for the client that methods of communication other than talk exist.

There are many ways of introducing art-making into the therapy process. For example, in the early stage of therapy, when the therapist is finding out about the client's world, they might say to the client that it would be helpful if they could create an image of all the people in their family and how they relate to one another, or construct a timeline that depicts where they are now, along with how they got there and where they are going. At later stages in therapy, it may be useful to invite a client to create an image to convey their sense of a difficult and painful emotional state ('what it feels like to want to cut myself') or to capture the memory of a dream. Lee et al. (2017) studied the effectiveness of an approach to therapy for depression that incorporated a series of art activities appropriate to different stages of therapy.

Drawing can be included in therapy in a variety of ways. Gerald Oster (2016; Oster and Crone 2004) has assembled a wide range of examples of drawing techniques that can be used at different stages of therapy, with different client issues and ages of client, and in both group and individual formats. Sometimes the therapist will ask the client to make a drawing of a particular person, their family, or a house. In the context of eco-therapy work (Chapter 17), Davis (2017) asks client to draw pictures about nature. Within narrative therapy (Chapter 14), the Tree of Life drawing exercise is widely used (Denborough 2018).

Interactive drawing therapy (IDT) involves the client drawing and mapping as they talk, all the way through therapy, with the therapist occasionally holding up the page so that the client can reflect on the whole picture or diagram that they have created (Everts and Withers 2006; Stone and Everts 2006; Withers 2006; Zhang and Everts 2012). This is an approach that most therapists can master fairly readily, and which is helpful for many different types of client. One of the advantages is that it enables a visual archive of the process of therapy to be created, including a depiction of whatever change has been accomplished. A further strategy, used by some therapists, is for the client and therapist to draw in response to each other, as a kind of visual conversation.

A widely used art therapy technique that involves materiality, collage, and sculpting is sand tray therapy, in which the client is invited to engage in self-expression by selecting figures and objects, placing them in a sand tray, and talking about their experience as they are doing this (Fleet et al. 2016; Homeyer and Sweeney 2016; Lowenfeld 1939). Sand trays have been used in therapy with both children and adults, either as part of a broader play therapy approach or as an adjunct to routine talk therapy.

Many visual art exercises and techniques that can be used in therapy are available in Buchalter (2009), Makin and Malchiodi (1999), Malchiodi (2004a, 2004b), Schroder (2004), and Silverstone (2009).

## Photography

While painting, drawing, and sculpting are activities that reach back to the origins of humankind, photography represents a much more recent form of making visual images. And the development of mobile phones with camera technology, coupled with the capacity to share pictures online, has expanded the possibilities of photography as an expressive outlet (Loewenthal 2013).

Unlike traditional visual arts, photography is an art discipline that has not, to date, generated a distinct professional identity and structure. Instead, different therapists have evolved their own ways of working therapeutically with this medium. The use of photographs in therapy can be as simple as inviting a client to bring with them some family photographs, and use these to talk about their relationships with other family members (Berman 1993; Weiser 1999). It is also possible to encourage clients to take photographs that will be specifically used in therapy. Ziller (2000) devised a method of 'photo self-narrative' where the client is invited to take photographs that represent their life-story. Loewenthal (2015) has devised a method that involves the therapist offering a set of 50 or so photographs to the client, who is invited to select one at a time and talk about what it means to them or evokes in them. This approach has been used with clients in schools and prisons and has proved to be very helpful in enabling clients to begin to open up and talk about issues in their lives.

'Photovoice' is a photography-based technique that combines individual and group therapy with community action. For example, in one project, young people in a deprived inner-city area were given disposable cameras and invited to take pictures that they considered portrayed 'success'; they then discussed these images together in a group setting (Smith et al. 2012). Two main benefits were reported by the participants in this project: they were more able to be 'agents' in their own lives and they were given the opportunity to reflect on, and make sense of, key dilemmas facing them in the process of growing up. These outcomes capture some of the central therapeutic possibilities for the use of photography in therapy. A further development in the use of photography for therapeutic purposes has been the move into video- and film-making (Cohen et al. 2015).

## Writing

The use of creative writing in counselling and psychotherapy is possibly the most widely deployed and comprehensively studied example of therapeutic art-making. In part, this is because we live in a literate society, in which the value and power of written language is taken for granted. There are also many different forms of writing that can be deployed: diaries, letters, poems, autobiography, etc. But the salience of therapeutic writing also owes a great deal to the impact of a highly influential programme of research carried out by James Pennebaker and his associates. In a series of studies, Pennebaker and his colleagues (see, for example, Pennebaker 2004a) invited participants simply to write for 15 minutes every day, over a period of four or five days, about the 'deepest emotions and thoughts about the most upsetting experience in your life'. Research participants who were randomly allocated to a control condition were asked to write about trivial matters. In various studies, the researchers tracked the impact of this brief writing intervention on a range of indicators of mental and physical health. What they found was that writing about mundane topics had no health impact. However, those who had written about stressful experiences exhibited a range of significant health benefits, including a reduction in the number of visits to see their doctor.

This technique has subsequently been adopted as a stand-alone self-help method (Pennebaker 1997, 2004a), as a means of helping people to cope with serious health conditions (Bolton 2008; Davidson et al. 2002; Lepore et al. 2002; Stanton and Danoff-Burg 2002), and as an adjunct to psychotherapy (Batten et al. 2002; Graf et al. 2008; Green Lister 2002, 2003; Kerner and Fitzpatrick 2007).

Because therapeutic writing has been examined in a number of carefully controlled studies, it has been possible to begin to identify the constituent healing elements of the writing process that

contribute to the enhancement of well-being in the person doing the writing. There appear to be three main helpful aspects of this type of activity (Pennebaker 2004b; Sloan and Marx 2004):

- 1 *Physiological.* Inhibiting ongoing thoughts, feelings, or behaviour is associated with expenditure of energy at a physiological level. Short-term inhibition is manifested in increased autonomic nervous system activity. Long-term inhibition serves as a low-level cumulative biological stressor that can cause or exacerbate a variety of health problems, ranging from colds and flu to heart disease and cancer.
- 2 *Cognitive.* Active inhibition of memories of stressful events is associated with deleterious changes in information processing. In holding back significant thoughts and feelings associated with an event, individuals do not process the event fully, and are left with ruminations, dreams, and other intrusive cognitive symptoms. Confronting traumatic memories can help negate the effects of inhibition, by reducing the physiological work put into inhibition, and by enabling individuals to understand and assimilate the event.
- 3 *Social.* The stressful events that people write about often involve relationships with others, and the process of writing allows these relationship difficulties to be viewed in perspective and to some degree be resolved. When people write about a problem, they are also more likely to talk to others about the issue, thus enlisting social support.

Research into the ‘Pennebaker paradigm’ has also clarified some of the conditions that need to be in place in order for therapeutic writing to be effective. The activity of writing needs to have an emotional dimension – the helpfulness of writing depends on whether the person has used writing as a means of accessing and expressing painful emotions. The writer needs to persist with the task. Typically, participants in the Pennebaker studies did not enjoy writing about stressful experiences, particularly at the outset. Finally, it seems to be helpful if there is no expectation that anyone else will necessarily read what has been produced, and the person can share the products of their writing with whom they wish and at a time that is appropriate for them. The privacy dimension of the writing experience is also linked to the importance for the writer of having permission to ignore grammatical conventions and spelling rules, and simply express things in their own way.

The work of Pennebaker has stimulated a range of initiatives around the use of structured writing activities in therapy, for example around helping clients to overcome the effects of trauma (Lange et al. 2003; Pass 2012; van Emmerik et al. 2008). However, it is clear that there are many ways in which therapeutic writing can be taken further, by drawing on long-established narrative and literary traditions. There are many genres of creative writing that have been used for therapeutic purposes, including journal writing, poetry writing (Tegner et al. 2009), and story writing. Within each of these genres, guidelines have been developed around specific writing tasks or exercises that can be used by individuals on their own, or in the context of therapy (see, for example, Adams 1998; Baldwin 1992; DeSalvo 2000; Fox 1997). It can be valuable to carry out therapeutic creative writing in a group setting, in which stories and other written outputs can function as a means of connection between members (Huss et al. 2009). One of the major advantages of writing as a therapeutic activity is that it is a method that is available to the majority of people. In addition, there are many forms of writing, ranging from the highly structured (e.g. thought diaries used in CBT) through to forms of writing that encourage improvisation and experimentation (e.g. certain types of poetry).

Kerner and Fitzpatrick (2007) have constructed a two-dimensional model of therapeutic creative writing. They suggest that creative writing techniques can be more cognitive-focused or more emotion-focused, and at the same time either structured or more open-ended. For example, a client could explore emotional issues by keeping a mood diary (highly structured) or writing a poem (unstructured). At a different time, the same client might seek to clarify the cognitive meaning of their experiences by following the prompts in an online programmed writing package, or by writing an autobiography. However, some writing techniques are hard to categorise (for instance, the

experience of writing an autobiography may move back and forwards between moments of high emotional intensity and moments of analytic reflection). Kerner and Fitzpatrick's (2007) model offers a framework to guide therapists and clients in their decisions around which writing approaches might be most relevant at particular points in therapy.

A rich literature is available on how to use creative writing in therapy – Bolton et al. (2004) provide a good entry point to this resource. Further information about poetry therapy can be found in Mazza (2016) and there is also a well-established professional interest group around this approach ([www.lapidus.org.uk](http://www.lapidus.org.uk)).



### **Case study 16.1: Re-weaving the self – creative writing following the death of a child**

Psychotherapist Judith Ryan wrote a paper in which she described how she used creative writing to 're-weave' the 'terrible rent in the fabric of the self' caused by the death of her 23-year-old son, Sean, in a climbing accident. In a state of profound dissociation following the loss, it took six months before she could write. Her first journal entry described her feelings of confusion, her difficulty in remembering her son in her dreams, and her sense of relief at recovering one strong dream image of him. Within a few weeks, her writing began to shift into a more direct style of expression of emotions. At around six months after the first journal entry, Judith joined a writing group: writing became a means of connecting with others. After two years, her writing was able to celebrate her son's life, and its meaning for her. She observed that, eventually, she arrived at a point where she was able to 'think of writing as Sean's legacy to me' (2009: 537) in terms of her own learning. This paper is a remarkable and unusual piece of work: Judith Ryan is a sensitive and skilled observer of her own emotional processes, who has the courage to share her learning with others. What this case report shows us is the way that the meaning of writing can change over a period of time, initially being a mechanism for coping with awful feelings and memories, then becoming an integral part of a person's sense of who she is.

## **Music**

Music is a central aspect of being human. In everyday life, music contributes well-being in a wide variety of ways (MacDonald 2013). Music is used to regulate emotion (Saarikallio 2011; Skånland 2013) and energy levels. Music can be a source of meaning-making: intense musical experiences can change lives (Schäfer et al. 2014). Learning to play an instrument is an accomplishment that can be rewarding and satisfying. Music is both part of broader cultural identity and more local connection. For example, most people can sing. Singing is a bodily activity that encourages breathing and allows people to be joined in shared rhythmic movement, as well as being a form of self-expression and meaning-making. Studies of the experience of being a member of a choir have shown that this activity is typically reported as joyful and life-enhancing, and a way of maintaining supportive relationships (Judd and Pooley 2014; Pearce et al. 2016).

All of these processes are brought into music therapy. There are many forms of music therapy, reflecting different theoretical perspectives and the needs of different client groups. Information about current developments in music therapy theory, practice, and research can be found in Bonde and Trondalen (2012) and Edwards (2016). A distinctive characteristic of music therapy is the way that shared music-making facilitates relational attunement between client and therapist. For example, shifts in emotional state, conveyed by subtle musical clues, may be more readily apparent than in conventional talk therapy.

There are also therapeutic applications of musical experience that would not be considered as formal music therapy. A technique that has been used in group and community-based work has been to invite participants to work together to write and perform a song (Denborough et al. 2008). Duffey (2005; Duffey et al. 2008) has developed a framework for working with older people around compiling a musical autobiography. There are many examples of the therapeutic use of specific culturally and personally meaningful musical genres (see, for example, Washington 2018). Beyond these examples that have been written up in the professional literature, many therapists invite clients to talk about the place of music in their lives, or ask clients to bring in to therapy pieces of music that might allow the therapist to gain a better appreciation of their particular emotional state or life experiences. Music can also be used in therapy as a means of facilitating relaxation and self-soothing.

## Drama

As a recognised art form, theatre has been part of the cultural landscape for most of human history, and may have its origins in religious ritual. However, dramatic enactment is also part of everyday life. As a mode of storytelling, people are able to illustrate events that have occurred through action, props, and the use of different voices. Key figures in the development of ways of using drama for therapeutic purposes include Jacob Moreno (1889–1974) and Zerka Moreno (1917–2016). An overview of their contributions to psychodrama and sociodrama can be found in Nolte (2014). The subsequent evolution of dramatherapy is described in Langley (2006).

Dramatherapy is a recognised therapy profession, with its own training, theories, and areas of application. An important aspect of the process of dramatherapy is that it gives participants opportunities to enact scenes or recurring patterns of interaction from their lives, by using other members of their therapy group as actors in their personal drama. This allows the person a perspective from which to observe and reflect on their behaviour. It also allows them to change the script, by re-enacting a scene in different ways. This type of activity is also emotionally involving, as well as functioning as a means of interpersonal support and solidarity. An important concept for the Morenos was spontaneity – the participant in psychodrama learns about the improvised nature of social life, and gains an awareness of what it means to make choices and take responsibility. In an enactment, the action can be paused at key moments to allow alternative ‘egos’ or voices within a protagonist to be expressed. Another valuable learning experience arises from being able to observe the dramas of other group members, or to take a role in their enactments. The therapist in a dramatherapy group functions to some extent as a theatre director, thus allowing interaction between group members to emerge as a meaningful source of support and meaning-making.

As well as operating within conventional clinical settings, drama can be used for therapeutic purposes in situations that are more oriented towards social justice and consciousness-raising, for example the theatre of the oppressed (Boal 1979, 1995) or the Playback Theatre (Rowe 2007). An emerging form of practice in this area is a genre of self-revelatory performance (Self-Rev), comprising a fusion of dramatherapy, autoethnography, and artistic expression (Emunah 2015; Pemdzik et al. 2016). There are also many links between the therapeutic use of drama and activities that take place in educational settings.

Alongside the therapeutic use of drama in dramatherapy and staged performances, there are several ways in which therapists draw on ideas and principles from drama within routine therapy. Two-chair work can be regarded as a method of creating a drama within a therapy session. Many therapists might invite a client to role-play an incident from their lives, perhaps with the therapist taking one of the parts. In couple therapy, clients may be encouraged to re-enact events that have been troublesome in their home life.

## Other ways of using art in therapy

There are several other forms of art that are valuable therapeutic resources but cannot be discussed here because of lack of space. These include dance, fashion, tattooing, interior design, art in nature,



website production and blogging, and multiple types of craft-making such as pottery, glass-making, weaving, quilting, knitting, metalwork, woodworking, and furniture making. Each of these activities can be highly significant to individuals, in similar ways to the mainstream art traditions described above. It is also possible to combine different forms of art activity in therapy (Colbert and Bent 2017).

As well as making art, therapy can involve being an observer or audience for art. Some therapists suggest novels, poems, and plays that their clients might read, or work on exploring the meaning of fictional writing or poetry that has special significance for the client. Possibly the most widely used approach within this category is *movie therapy*, in which the therapist may 'prescribe' a movie or watch a movie suggested by the client (Hesley and Hesley 2001; Lampropoulos et al. 2004; Schulenberg 2003; Wedding and Niemiec 2003; Wolz 2010). The therapeutic possibility afforded by watching a movie (or reading a novel) is that the client can identify with a character who may represent a constructive way of resolving the client's problem. Some movies and fiction may allow emotional catharsis. de Botton and Armstrong (2013) have described ways in which visiting an art gallery can be a therapeutic experience.

### Box 16.1: An expressive therapist's toolkit

Expressive or creative arts therapists generally use a range of art activities, selecting different ones to match the needs of particular clients at specific times. Examples of how one expressive therapist embeds expressive arts techniques into conventional verbal/conversational therapy can be found in Carrell (2001). One technique, the family memories exercise, involves giving the client a large sheet of paper and some coloured markers. The client is asked to draw a line down the middle of the page. On one side, they are asked to draw an unhappy family memory; on the other side, a happy memory. Carrell (2001) describes her use of this technique with Agneta, a woman experiencing a significant personal crisis. The unhappy image produced by Agneta portrayed a stick figure standing on a globe with outstretched hands reaching for an aeroplane flying in the sky. On being asked to talk about the picture, Agneta reported that it described a summer holiday as a child, where she had been left for several weeks with distant relatives in Europe, and had spent the whole time looking towards the sky for the plane that would take her back home to the USA. This theme of abandonment, which emerged for the first time through the picture-making activity, turned out to be the key to this client's current difficulties. In another example, Carrell (2001) also gives an account of how she might ask each member in a troubled marriage to buy a disposable camera and take a series of pictures that capture the way that they feel about the relationship. The clients are then invited to talk about their images.

## Therapeutic processes associated with the use of art in therapy

A number of therapeutic processes are associated with the use of expressive arts methods in therapy. These techniques engage the imagination of the person, and allow them to begin to stand back from the concrete situation that is bringing pain into their life and reflect on its meaning. Many arts techniques, such as painting, sculpting, and dance, are carried out in the absence of talk, and provide opportunities for the emergence of pre-verbal, unconscious, implicit, or hidden material – thoughts, feelings, and fantasies that might otherwise be hard to articulate. The creation of an object, such as a picture, has the effect of 'externalising' the problem, allowing the client and therapist to look at it together and to consider it as something slightly separate from the client, but around which they have expert knowledge (Keeling and Bermudez 2006; Rubin 2005). Art-making also introduces activity and 'doing' into a therapy session, which can enable the person to break out of passive states of mind. The making of an art object also represents a ritual that demonstrates to the person that it is



possible to be an active, purposeful agent in one's own life – doing things that lead step by step from one state of mind or emotion to another (Rolvstjard 2015). Many art-making activities are highly embodied, and help the person to get 'out of their head', in the sense of cutting through the flow of negative self-talk, and into a more direct mode of making contact with the world. The objects that are made in therapy, or even the images of moments in dance or drama sessions, function as tangible reminders of personal issues and insights, and moments of change in therapy. Most therapeutic art activities involve collaboration, sharing, and embodied attunement/synchrony between therapist and client, or between members of a therapy group. The making of an art object of some kind leads to the reception of that object by an audience. There is much personal learning that can occur during this process, including the possibility for experiencing a more accepting and less harshly critical response than the person might have encountered from parents or teachers in their early life. In this sense, art-making has the potential for dissolving shame. In a broad sense, any type of 'making' is a way of connecting with others (Gauntlett 2018). Finally, art participation can help a person to connect with cultural traditions, thus opening up access to social capital.

Jerome Bruner is regarded as one of the most influential psychologists of the twentieth century. Among his many contributions to the discipline is a model of learning that has important implications for the way that we understand the role of art-making activities in therapy. Through extensive observation of infants and children, Bruner (1966, 1973) realised that learning involves moving through three quite distinct modalities of representation: *enactive*, *iconic*, and *symbolic*. For example, in learning about the weight of objects, a child will first of all experiment with picking things up (action-based learning), then will be able to use mental or visual *images* (this toy car looks heavier than that one), and then will become able to use abstract symbols (words, numbers) to represent how much things weigh. Effective learning experiences allow the person to access all three modes of representation, as necessary. 'Ordinary therapy', where client and therapist just talk to each other, takes place almost entirely in the domain of symbolic knowing. By contrast, drawing a picture or writing a story allows the client to shift back and forward between enactive, iconic, and symbolic realms in ways that can be therapeutically helpful.

The impact and meaning of arts-informed therapy practice can be understood in terms of its ability to offer a more focused and intensive engagement with processes that occur in all forms of therapy. It is clear that art-based work places a strong emphasis on the use of creativity, in the form of using imagination and envisaging novel solutions to problems (Carson and Becker 2003; Gladding 2011). It also heightens the use of intuition – the capacity to trust immediate non-logical responses to situations (Bohart 1999; Dodge Rea 2001; Welling 2005). Arts therapies also generate many opportunities for the experience of play, and the application of a playful attitude to learning. An art perspective also invites consideration of principles of design, for example designing a therapy intervention or homework task that is fit for purpose (McLeod 2017a).

Expressive methods provide a fertile arena for building and exploring the client–therapist relationship. The process of deciding on which media are to be used, how, for how long, and for what purpose, opens up an array of opportunities for collaborative decision-making. There may be valuable exploration around the feelings that the client may hold regarding showing the eventual object to their therapist. Is the therapist regarded as a potentially destructive critic of the art object, or as a loving parent welcoming their child's latest efforts? In either case, where do these feelings come from, and what might they mean? Is the therapist trusted to touch or to hold the art object? Are they sensitive enough to ask whether it is alright to touch or hold it? The interplay between client and therapist around the art object allows the latter many ways of offering (or failing to offer) the 'core conditions' of acceptance, empathy, and congruence.

Because psychoanalysis was the earliest form of psychotherapy, and so was the first approach to 'discover' the therapeutic potential of the arts, and because so much expressive work in the arts operates on the borderline between the conscious and unconscious, much of the theory that has grown up around arts therapies has been psychoanalytic and psychodynamic in nature. The fascination of Carl Jung with imagery and the creative process has also meant that there is a rich tradition of Jungian theorising within art therapy. More recently, however, influenced by the writings of

Natalie Rogers (2000), Liesl Silverstone (1997), and others, there has been a movement in the direction of a more theoretically integrationist approach to expressive therapy, drawing on theoretical ideas from the person-centred, gestalt, and CBT perspectives. Humanistic and spiritual perspectives on the therapeutic use of art are explored by McNiff (2004).

### **Box 16.2: Research into the client experience of making art**

In a study by van Lith et al. (2011), clients who had taken part in an art therapy group were interviewed about their experiences. Analysis of the interview transcripts identified three main themes. First, there was a sense of freedom, creativity, and acceptance associated with the process of making art. In other words, art-making was regarded as an enjoyable, valued, and meaningful experience in itself. Second, creating an image was a tangible task. The person could become absorbed in the task, and gain a sense of accomplishment when an image took shape in a satisfactory manner. Third, there was an intense relationship with the image itself. The image was a vehicle for self-expression and insight. It also functioned as a means of communicating with others, and an indicator of therapeutic progress. Participants also talked about how the image ‘gave them something back’. One client said ‘that’s my picture on that wall; it gives me an amazing sense of achievement’ (van Lith et al. 2011: 657). It was as though there was a point at which an image had a life of its own, and its creator could both learn from it and gain a sense of affirmation through the extent to which other people appreciated it.

Similar themes have been found in other research on the client experience of therapeutic art-making, including Griffiths (2008) and Reynolds et al. (2008).

## **Art as a way of making sense of therapy**

The contemporary counselling and psychotherapy literature is dominated by an underlying assumption that it is desirable to view therapy through the lens of science: therapist as scientist-practitioner. There is also an older tradition of therapist as healer, or wounded healer. However, it is also possible to view therapy through the lens of art. Much of the discussion in the present chapter has sought to make sense of the therapeutic value of art in terms of concepts and theories from psychology. Bohart (1999) suggested that, in everyday life, people rarely make sense of what is happening in terms of scientific models. Instead, we draw on a more intuitive and aesthetic understanding based on a capacity to see patterns, see things as whole, and notice when something just does not fit – just the kind of thinking that is involved in art-making. In interviews with therapists who were also artists, Rouse et al. (2015) found that participants described themselves as using an art sensibility to guide their work with clients – for example, finding connection and coherence across different kinds of experience. Similar ideas have been expressed in papers by Johnson (2018), who made sense of his work as a therapist through seeing it as similar to a jazz performance, and Schwartz (2018), who based her therapy practice on her experience as a painter. Gompertz (2015) analysed what is involved in ‘thinking like an artist’ – the list of attributes that he came up with look very much like a prescription for being a good therapist. One of the characteristics of art-making that is emphasised by Gompertz (2015) is how hard an artist needs to work.

## **Art as a means of communicating the findings of research**

The relevance of research evidence for therapy practice represents a problematic issue for the profession – therapists tend not to read research, and efforts to develop evidence-based practice do

not necessarily lead to improvements in the effectiveness of therapy. There are many reasons why research and practice are not as well aligned as they might be (McLeod 2016). One of the factors is that conventional research papers do not do a particularly good job of conveying the lived, embodied experience of clients and therapists, or the emotional reality of the work. Art-based formats for disseminating research findings, such as video, installations, museum exhibitions, and theatrical plays, are increasingly making an important contribution in this area (Carless and Douglas 2016; Douglas and Carless 2018).

## Conclusions

Expressive arts methods represent the assimilation into therapy of timeless cultural traditions and practices – the capacity to symbolise experience in art works, the motivation to make objects and moments that are ‘special’, and all the ways that making enables connection. Such an approach brings back into therapy crucial aspects of what it means to be human that have been occluded by the purely psychological image of the person that has held sway over the profession. It is possible to integrate expressive arts methods sensibility into any therapy situation. An appreciation of the value of an aesthetic perspective on therapy requires a capacity to place contemporary ideas about art into a historical perspective. For a variety of reasons, such as technologies that enable access to mass-produced visual images and sound recordings, art in modern society has become a commodity, and most people have become passive consumers of art. This situation does not reflect the deeper cultural meaning of art, and the reasons why art is such a significant force in human life. The aboriginal paintings and Native American carvings that can now be seen in museums and galleries, or on the internet, were once integral elements of community life. The people who made these objects were not regarded as ‘artists’ who had a separate existence to everyone else. Similarly, up until quite recently, individuals in European societies only had access to music through their own capacity to play instruments or to sing in Church, or while they worked, or at gatherings. The use of art in therapy is a form of re-establishing and reclaiming these old traditions, and all that they imply.



### Topics for reflection and discussion

- 1 Reflect on the significance that art-making has had in your own life. In what ways have writing, drawing, painting, music-making, or other forms of artistic expression had a ‘therapeutic’ effect for you? What is it about these activities that has been helpful for you?
- 2 Identify one poem, novel, movie, or play that has had a lot of meaning for you. How and why did that particular piece have the effect it did?
- 3 To what extent are the arts-based approaches described in this chapter generally applicable to *all* types of presenting problem? For any one of the approaches (e.g. drama, sand play, photography), list two or three types of problem or client group for which it would be likely to be *most* or *least* helpful.
- 4 How important is it for a therapist to have an artistic sensibility, for example to be able to be intuitive, playful, and creative? Is this kind of perspective more important than being scientifically informed or able to think theoretically?
- 5 What are the implications of the ideas and themes discussed in this chapter for therapist training?

## Suggested further reading

To develop an appreciation of the significance of art-making in human living, it is worth becoming familiar with the ideas of Ellen Dissanayake, for example her classic book *Homo Aestheticus: Where Art Comes From and Why* (Dissanayake 1992). *Think Like an Artist* (Gompertz 2015) is a succinct and accessible introduction to the meaning and implications of engaging in art-making. Marion Milner was a psychoanalyst who wrote about her own personal experience as an artist. Her book *On Not Being Able to Paint* (Milner 1957; originally published under a pseudonym in 1950) was highly influential in conveying an appreciation of the dynamics of art-making to therapists. *The Arts in Psychotherapy* and the *Journal of Creativity in Mental Health* are consistently interesting and worth reading and contain articles on clinical practice, training, and research in all forms of expressive arts therapies. A workbook that provides many strategies for tapping into the basic human capacity for creativity and imagination that underpins all arts-oriented therapy is *The Artist's Way* by Julia Cameron (1994). A short paper by Dieterich-Hartwell and Koch (2017), based on their experience of using arts therapies with refugees in Germany, provides a powerful summary of the ways that art can enable people to create a sanctuary and 'temporary home' through periods of extreme personal crisis.

# Chapter 17

## Therapy in nature: using the outdoor environment

<b>Introduction</b>	<b>252</b>
<b>The health benefits of being in an outdoor environment</b>	<b>253</b>
<b>Forms of outdoor therapy</b>	<b>253</b>
Ecopsychology	253
Adventure/wilderness therapy	254
Nature therapy	255
Horticulture therapy	255
Animal-assisted therapy	256
Taking ordinary talk therapy out of doors	256
<b>Political and social justice dimensions of outdoor therapy</b>	<b>257</b>
<b>Research on outdoor therapies</b>	<b>257</b>
<b>Conclusions</b>	<b>257</b>
<b>Topics for reflection and discussion</b>	<b>258</b>
<b>Suggested further reading</b>	<b>258</b>

### Introduction

Most counselling and psychotherapy takes place indoors, usually in a fairly small room. There is, however, an alternative that is increasingly widely used, which is to conduct therapy out of doors, preferably in locations that allow contact with nature. The use of the natural environment as a setting for therapy has the advantage of providing an opportunity for different types of therapeutic process to occur. Some proponents of the use of outdoor therapy also believe that contact with nature has an intrinsic healing capacity.

The use of nature in therapy has been influenced by ideas from ecology and environmental studies. The Norwegian philosopher Arne Naess (1989) invented the phrase *deep ecology* to refer to the natural world and the ecological connections between all things as a profound source of wisdom, which is largely ignored and discounted in the modern urban world. Books such as *The Spell of the*

*Sensuous* (Abram 1996) and *Coming Back to Life* (Macy and Brown 1998) have been highly influential in conveying the possibilities of a sense of connectedness to the natural world that is missing in many people's lives, and the healing potentials that are triggered by making contact with this dimension of experience. An important strand within these writings has been the argument that there is a moral and ethical aspect to the relationship between human beings and nature: it is not ethically acceptable merely to 'use' nature, and there is an overarching ethical imperative to respect the right to exist of animals, plants, and habitats. This perspective has been further developed by various *ecofeminist* writers, who suggest that there is a connection between the oppression of the Earth and the oppression of women (Adams 1993; Plumwood 1993).

The aim of this chapter is to provide an overview of different strands of theory and practice in relation to counselling and psychotherapy that is conducted in outdoor settings. At the present time, there is no unified model of outdoor therapy. There are many examples of this kind of work that involve collaboration between therapists and practitioners of other disciplines (e.g. outdoor pursuits instructors, wilderness guides). As a result, 'outdoor' therapy has not yet found a single professional 'home', but instead straddles a number of professional domains.

## The health benefits of being in an outdoor environment

An important aspect of outdoor therapy is that there is plenty of evidence that spending even a small amount of time in the natural environment, or even being able to look at hills, trees, and seascapes through a window, can have a powerful beneficial impact on health and well-being (Barton and Pretty 2010; Coon et al. 2011; Mitchell 2013; Pinquart et al. 2007) and on the efficiency of cognitive functioning (Berman et al. 2008). Moreover, most people believe that being outdoors, being at one with nature, and exercising are healthy pursuits (Parker and Crawford 2007). As a result, many therapy clients do not need to be convinced that there may be some merit in conducting all or part of their therapy outside of an office environment. People who seek therapy may already be engaged in outdoor activities, may have past experience of this kind of endeavour, or may be open to trying new types of nature-based experience. The challenge for therapists has been to find safe, effective, and affordable ways of channelling these tendencies to respond to the needs of different client groups.

## Forms of outdoor therapy

There are various strategies for conducting counselling and psychotherapy in outdoor settings. These different approaches reflect the diversity of possibilities that are opened up by moving therapy out of the office. For example, it becomes possible to think in terms of walking around a park that is close to a therapy office or clinic, or relocating entirely to a wilderness area. The different outdoor therapy approaches also reflect a variety of ideas about what is helpful for clients. For instance, some approaches emphasise the basic transformational power of merely interacting with nature, while others emphasise the opportunity to overcome physical challenge or the opportunity to be part of a group. These (and other) change processes are combined in different ways within different outdoor therapy traditions.

## Ecopsychology

A significant theoretical influence on the development of approaches to counselling that involve nature and the outdoor environment is *ecopsychology* (Higley and Milton 2008; Roszak et al. 1995; Totton 2012). The work of writers, theorists, and practitioners within the ecopsychology movement extends far beyond the domain of counselling and psychology – ecopsychology represents an attempt to re-focus the whole of psychology, including developmental psychology, social psychology, and evolutionary



psychology. Initially, ecopsychology adopted a largely psychoanalytic approach, in using terms such as the 'ecological unconscious'. More recently, ecopsychology has redefined itself as a broad field of inquiry, which does not prioritise any one particular psychological approach over another. Because ecopsychology, deep ecology, and ecofeminism are broad philosophical and theoretical approaches, which embrace a variety of interdisciplinary interests, they have tended not to have generated a specific model of therapy practice. Instead, the ideas and principles of ecopsychology have permeated different approaches to the practice of outdoor/nature-oriented therapy in a variety of ways.

## Adventure/wilderness therapy

In terms of practical application, the earliest approaches to use of the outdoor environment for therapeutic purposes were adventure therapy and wilderness therapy. *Adventure therapy* emphasises the use of physical and psychological challenge (Ray 2005; Richards and Smith 2003). For example, success in abseiling down a cliff, climbing a rock face, or traversing a high rope ladder may have a highly positive impact on a person who suffers from low self-esteem, and the memories of their achievement may help to maintain that gain in everyday life. The adventure therapy approach has its origins in the Outward Bound tradition developed in Britain in the 1950s. *Wilderness therapy* makes similar use of challenge, but in this case the risk is not designed or planned by the facilitators, but is inherent in the experience of trekking through wild countryside or canoeing down a gorge (Greenway 1995; Plotkin 2001). The experience of undergoing a wilderness experience acts as a metaphor for the personal journey that the person is undertaking (Corazon et al. 2011; Hartford 2011). The person travels away from their normal routines and everyday reality, and further and further into a new and unknown reality (McDonald et al. 2009).

Typically, adventure therapy and wilderness therapy are conducted in groups, thus introducing therapeutic processes such as the experience of group cohesiveness and a sense of belonging, and receiving support and feedback from other group members. Adventure therapy and wilderness therapy have mainly been practised within educational organisations, with specific groups of people – such as those with a drug problem and young people with conduct disorders – rather than being applied to a wider population of people with anxiety, depression, and relationship difficulties. These methods have also been applied in the field of counsellor training (Wheeler et al. 1998). Adventure therapy can also be combined with indoor one-to-one therapy. For example, Kyriakopoulos (2010, 2011) offered clients of a university student counselling service an opportunity to take part in a brief adventure therapy workshop. Clients were able to use their ongoing relationship with their counsellors (who did not take part in the workshop) to explore and work through the meaning of these experiences. In follow-up interviews, the majority of clients reported that the adventure activities had made a positive contribution to their therapy.



### Case study 17.1: Adventure therapy in action – overcoming eating disorders

An example of how outdoor therapy can operate is provided by Richards (2003) and Richards and Peel (2005), in their study of the effectiveness of adventure therapy with a group of women suffering from intractable eating disorders that had not been dealt with in previous episodes of conventional indoor therapy. These women spent five days engaged in a series of challenging outdoor activities, involving canoeing, climbing, and walking. The programme was facilitated by outdoor pursuits experts working alongside counsellors, and the women were invited to talk about their experiences following each activity. Most of the women who took part in the programme reported significant gains in terms of a lessening of their eating disorder symptoms. Some of the women found the experience to be transformational, and felt that they had been able to experience themselves in

a completely different way, emerging with a greater sense of self-confidence. The therapists who were part of the team of facilitators observed that the women undertaking the programme were able to begin to explore significant personal issues much more quickly, and in more depth, than they would have expected in a conventional therapy relationship.

The results of this study illustrate some of the processes that can make outdoor therapy so effective. The person seeking help is exposed to new experiences that invite them to view themselves in a new light. They are invited to exhibit new behaviour and strengths. All this takes place in a context of high challenge and high group support, away from pre-existing everyday contexts that might trigger old patterns of feeling, thought, and action. Taken as a whole, the experience is emotionally and physically intense and vividly memorable, and can readily become a turning point or epiphany moment in a person's life.

## Nature therapy

A fully developed framework for the use of the natural world in therapy is the *nature therapy* approach created by the Israeli therapist Ronen Berger (Berger 2004, 2005, 2016; Berger and McLeod 2006). Nature therapy is an integration of creative arts therapies along with ideas from other therapeutic approaches such as psychodynamic, gestalt, and Jungian. A key idea within nature therapy is the concept of the 'three-way relationship', between the client, the therapist, and nature. Each participant in this relationship can affect, and be affected by, the other. Nature is regarded as a force that has its own influence on a person. For example, during a nature therapy session, a person may walk up a hill in a strong wind and feel cold. This experience may trigger thoughts and fantasies about being vulnerable. A moment later, the sun comes out and the person feels its warmth, which may evoke images of safety and nurturance. Part of the role of the therapist is to choose environments that have the possibility of stimulating particular types of experience in a group of participants. For example, the time of sunset and the onset of darkness has the potential to elicit feelings of loss, whereas a tidal shore has the potential to elicit an awareness of cyclical change and renewal. Nature therapy makes use of ritual to intensify the person's contact with the natural world. The client is encouraged to find and make a 'home in nature', which comes to represent a form of 'secure base' within which difficult personal issues can be explored.

Nature therapy has been applied to a range of problems: PTSD, children with learning difficulties, anxiety, and depression (Berger 2016). The therapeutic process that takes place within nature therapy operates in two dimensions. Primarily, it offers clients the same kind of therapeutic experiences they would have in other therapies, including a relationship with a therapist, an opportunity to remember, to tell their story and reflect on their experience, and the chance to experiment with different behaviour. Beyond this, however, nature therapy produces a sense of interconnectedness with the natural world, an awareness of something that lies beyond human-made objects and activities. This awareness can contribute to the development of a broader perspective on life that can be valuable in many situations. In addition, for a person who has experienced nature therapy, the natural world becomes more of a resource in their life as a whole.

Berger and Lahad (2013) have published a manual for the use of nature therapy with children who have experienced trauma. An edited collection of papers by Kopytin and Rugh (2017) provides information on a range of expressive, arts-based outdoor therapies that are consistent with the nature therapy approach.

## Horticulture therapy

A contrasting approach to outdoor therapy is to combine therapeutic work with gardening and horticultural activities. One of the best examples of this approach comes from the work of the Medical

Foundation for the Care of Victims of Torture, in London, with people who have been exiled from countries and have been traumatised by the torture they have seen or received (Linden and Grut 2002). In this project, gardening experts and psychotherapists work alongside the person in their plot. The role of the therapist is to enable the person to use the process of gardening to express and reflect on their experience. For example, cultivating crops that were familiar to the person from their home country can have great meaning. The experience of growth and renewal that comes from starting with bare earth and ending up with food that can be shared with the group, and used to feed one's own family, allows the person to begin to move beyond a sense of hopelessness and despair. Tending a memorial garden gives a tangible way of remembering those who have been left behind. The key to the therapy that is described by Linden and Grut (2002) is that the natural world, in the form of an allotment, has the capacity to evoke emotion and memory, which can then be shared and discussed with the therapist who is on the spot.

A broader tradition of horticultural therapy is described by Simson and Straus (1997). Corazon et al. (2012) have developed a model of horticulture therapy that integrates practical plant-care work with therapeutic activities from mindfulness and acceptance-oriented therapies.

## Animal-assisted therapy

Many therapists encourage clients to interact with, or care for, animals for therapeutic purposes. Being involved with animals helps to slow the person down, has the potential to expose them to unconditional acceptance, puts them in a situation in which they are called on to communicate in a direct and authentic manner, stimulates positive emotions, and can provide a channel for meeting other people and receiving social affirmation. Involvement with animals may also take the person out of doors. There have been many forms of animal-assisted psychotherapeutic initiative (Fine 2010), and research suggests that animal-assisted therapy can improve the outcomes of therapy for many clients (Hoagwood et al. 2017).

The most widely used therapy approach involving animals is equine-assisted therapy (Trotter 2012). The efficacy of this approach has received considerable research support (Kendall et al. 2015). Horses are highly responsive to human emotions, and therapy clients who engage in equine therapy typically report that they develop a strong bond with their horse (Kern-Godal et al. 2016; Tuuvas et al. 2017). A protocol that builds on this aspect of equine therapy, through drawing on theory and practice in mainstream emotion-focused therapy, has been developed by Johansen et al. (2014).

Many counsellors and psychotherapists use dogs on an informal basis in therapy. This form of animal-assisted therapy can take place indoors or outside. Although it has not received the same research attention or professional recognition as equine-assisted therapy, there is evidence that contact with a therapy dog can help to regulate disruptively high levels of client anxiety (Hunt and Chizkov 2014) and can encourage child clients who have been sexually abused to remain in therapy (Signal et al. 2017). Jenkins et al. (2014) found that clients of a school counselling service formed strong relationships with therapy dogs.

## Taking ordinary talk therapy out of doors

Several other approaches to using the outdoors in therapy have been developed in recent years. Burns (1998) has described a form of 'nature-guided' therapy that is largely based on a conventional office consultation but the person is encouraged to reflect on their involvement in nature, carry out a series of outdoor homework exercises that are designed to deepen the significance of nature as a source of personal meaning, and to use outdoor activities as a way of coping with emotional problems. In a similar fashion, the gestalt therapist William Cahalan (1995) mainly works with his clients in an office but moves into outdoor spaces to explore specific issues, particularly in relation to restoring the client's sense of *contact*, a key concept within gestalt theory. Doucette (2004) introduced the concept of 'walk and talk' counselling: young people receiving therapy were given the option of counselling while walking around the grounds of their school. Jordan and

Marshall (2010) give their clients the option of meeting in a range of outdoor contexts, as well as in a therapy room.

Jordan and Marshall (2010) also offer a valuable discussion of the practical and conceptual issues involved in shifting the therapy 'frame' or 'space' into a setting such as an urban park. What happens if someone passes by while the therapist and client are in the middle of an intense conversation? What happens if a stray dog appears? What happens if the session runs over time because the client is walking very slowly? What happens if it rains? Jordan and Marshall (2010) suggest that it is essential for therapists who move their practice out of doors to consider these issues in advance, and to make the client aware of how to respond to the unpredictable challenges of conducting therapy out of doors. Further discussion of these issues can also be found in Hays (1999).

## Political and social justice dimensions of outdoor therapy

There are an increasing number of therapists who take the view that their work has a significant political dimension. The use of outdoor settings in counselling has the potential to make a positive contribution to individual and collective efforts to combat climate change and increase environmental awareness. Activities that enable therapy clients to appreciate the natural world, and to make connections between involvement in nature and personal well-being, may lead to greater awareness of the value of the natural environment and a willingness to act to conserve and preserve that environment. It is also possible that engagement with nature might be associated with a reduction in consumerism.

Some counsellors and psychotherapists have actively explored the interface between therapy and the environmental movement. Moir-Bussy (2009) and others have created theoretical bridges between these domains. Randall (2009) has used psychotherapeutic concepts to account for why the majority of the population are in denial about the threat of global warming, and uses therapeutic skills to facilitate groups in which participants can move in the direction of conscious acknowledgement and action. In turn, an understanding of the broader social and political meanings associated with concepts such as 'nature', 'wilderness', and 'landscape' has important implications for the conduct of outdoor therapy itself (Willis 2011). For some people, the outdoors represents a convenient and large-scale setting for aerobic exercise, or undertaking adventurous pastimes such as abseiling, that is simply an alternative to the gym or leisure centre. For others, being out of doors allows a spiritual reconnection with an essential aspect of what it means to be human, or commitment to a sustainable, eco-aware lifestyle.

## Research on outdoor therapies

There is a growing body of research, using both qualitative and quantitative methodologies, that supports the use of outdoor methods in counselling and psychotherapy. Evidence for the effectiveness of outdoor therapy includes studies and reviews by Aslan (2016), Bird (2015), Bowen et al. (2016), Harper (2017), Hennigan (2010), Oppen et al. (2014), Revell et al. (2014), Russell et al. (2017), and Scheinfeld et al. (2011). Research has also been conducted on the experiences of counsellors and psychotherapists undertaking outdoor work (Jordan 2014a; Kamitsis and Simmonds 2017; Revell and McLeod 2016, 2017). This body of evidence is valuable in identifying topics for further research, and establishing issues that need to be addressed in relation to the development of practice standards and training.

## Conclusions

Using the outdoor environment in counselling and psychotherapy is a significant emergent form of practice that is steadily entering the mainstream. It is clear that therapists intending to work out of

doors with their clients need appropriate training. For example, there are issues of safety involved in taking clients canoeing, or hiking into wilderness areas where they might be injured. There is also a need for further research into outdoor therapies, in terms of their effectiveness for different client groups, and into the therapeutic processes that occur. Nevertheless, it is clear that outdoor and nature-informed approaches to therapy will increase in the future, both in response to an increasing public awareness of the significance of the environment and because these approaches generate important possibilities for innovative ways of working with people to bring about meaningful change in their lives.



### Topics for reflection and discussion

- 1 Reflect on the impact that the outdoor environment has had in your own life. In what ways have walking, climbing, gardening, or other ways of being with nature had a 'therapeutic' effect for you? What is it about these activities that has been helpful for you?
- 2 To what extent are the innovative approaches described in this chapter generally applicable to *all* types of presenting problem? For each of the approaches, list two or three types of problem or client group for which it would be likely to be *most* or *least* helpful.
- 3 What are the therapeutic processes that are more likely to occur when therapy involves some kind of outdoor activity? What are the processes that are *less* likely to occur than in 'indoor' therapy?

### Suggested further reading

To gain an appreciation of the unique quality of enchantment that is associated with the discovery that being human involves being part of the natural world, there is no better book than *The Spell of the Sensuous: Perception and Language in a More-than-Human World* by David Abram (1996). Recent developments in outdoor therapy are reviewed in *Adventure Therapy: Theory, Research, and Practice* (Gass et al. 2012) and *Ecotherapy: Theory, Research and Practice* (Jordan and Hinds 2016). Particularly valuable resources are *The Healing Forest in Post-Crisis Work with Children* (Berger and Lahad 2013) and *Nature-Based Therapy: A Practitioner's Guide to Working Outdoors with Children, Youth and Families* (Harper et al. 2019) – the first published manuals of how to implement specific outdoor therapy interventions.

# Chapter 18

## Religion and spirituality

<b>Introduction</b>	<b>259</b>
<b>Spiritually and religiously informed therapeutic practice</b>	<b>260</b>
<b>Religion and spirituality as a resource</b>	<b>261</b>
<b>Therapy with members of specific religious faiths</b>	<b>263</b>
<b>Spiritual techniques in therapy</b>	<b>263</b>
Transpersonal psychotherapy	264
<b>Therapist attitudes and competence in working with religious and spiritual issues</b>	<b>266</b>
<b>The dark side of religion and spirituality</b>	<b>267</b>
<b>Conclusions</b>	<b>268</b>
<b>Topics for reflection and discussion</b>	<b>269</b>
<b>Suggested further reading</b>	<b>269</b>

### Introduction

Historically, people turned to priests, nuns, rabbis, imams, ministers, shamans, or other religious leaders when they experienced troubled relationships or a reduced capacity to cope with the demands of everyday life. Organised religions, and the spiritual practices embedded within them, provide a framework for finding meaning in life, a source of guidance and emotional support, and a pathway for personal development and actualisation. Counselling and psychotherapy emerged out of this tradition, as a secular and scientifically informed alternative to religion. A deliberate differentiation of psychotherapy from religion can be found in the writings of the pioneers of psychotherapy, such as Freud and Rogers, with the result that contemporary mainstream approaches to therapy take little account of religious faith or the spiritual aspects of life in both the development and alleviation of problems in daily living.

One of the most significant recent developments in the field of counselling and psychotherapy has been a gradual rediscovery of the importance of faith and spirituality. To some extent, spirituality never went away: influential therapy approaches such as Jungian, transpersonal, and psychosynthesis have always placed spirituality at the heart of their way of conceptualising the person. In addition, many counsellors and psychotherapists are personally committed to religious and spiritual practice and may even regard helping others through therapeutic work as a crucial aspect of



their religious calling. These underlying factors have been given greater force by the extent to which therapy has become more attuned to cultural diversity. For many communities, cultural identity means being serious about spirituality, religious teaching, and adherence to specific values. In these communities, religion and spirituality are an all-encompassing inherent and necessary aspect of everyday life, not an optional 'add-on'. This is just as true for some Christian cultural groups as it is for people who follow Islam or other world religions.

An interest in religion and spirituality has also been given impetus by the globalisation of therapy. While therapists trained in Europe and North America have found that their ideas and methods are not well aligned with the world-views of people in other cultures, they have also discovered that these other cultures have long-established healing rituals that can be applied in the West – activities such as mindfulness, meditation, yoga, drumming, and sweat lodges.

The wish to integrate a spiritual perspective into counselling and psychotherapy is not a straightforward matter. Some clients and therapists have no personal interest in spirituality. Others may have a strong but narrow interest, which may make it difficult or impossible for a therapist to engage with a client unless they share a particular spiritual path. People who seek help from a therapist are unlikely to view religion as a wholly satisfactory solution to their problems: if they did, there would be no reason to consult a counsellor or psychotherapist. Typically, therefore, therapy operates in a space of fragmented spirituality (Tacey 2013).

In the end, therapy is not a religion and is not primarily a spiritual practice. The challenges associated with sensitively honouring the religious beliefs and preferences of clients has generated a wide range of models of spiritually informed practice, and inspired a growing body of research. The present chapter offers an introduction to this territory.

## Spiritually and religiously informed therapeutic practice

Religion and spirituality are concepts that are fundamental to the experience of being human, and as a result refer to a complex array of phenomena that can be understood in a range of different ways (Hill et al. 2000; King and Koenig 2009; Paloutzian and Park 2015; Pargament and Saunders 2007). Broadly speaking, religion can be regarded as comprising an organised system of beliefs, practices, rituals, and symbols that represent an ongoing framework through which members of a religious community make sense of central issues of human existence such as morality, ways of relating to others, the nature of reality, and the meaning of loss and death. The integral strength and coherence of a religion is provided by rituals and practices (such as prayer) that facilitate access to a sacred or transcendent dimension of existence, such as God or a higher power.

By contrast, spirituality can be regarded as an individual experience that takes the form of a lived connection with a transcendent reality. Spirituality may be experienced as an energy or force that animates life, or a sense of connection with the universe. It implies a form of *relational consciousness* – the person is in relationship with something that goes beyond the individual ego or self, and leads to an understanding that there is meaning that transcends individual needs and goals. Religion and spirituality are interconnected, in that all religions incorporate some kind of spiritual practice, and most spiritual experiences are understood by the individual in relation to some kind of belief system. However, it is possible to participate in, and benefit from, organised religion at the level of social support and personal identity, with little or no spiritual engagement. Conversely, many people who report mystical or peak experiences do not interpret them in terms of any kind of religiously informed belief system, or take part in spiritual practices (such as yoga or meditation) without adopting the philosophical system that accompanies such disciplines. The concept of 'spiritual intelligence' has been proposed as an idea that encompasses all of these activities (Vaughan 2002).

The complexity of religion and spirituality means that they are relevant to counselling and psychotherapy in a number of different ways. In respect of widely experienced problems in living such as anxiety, depression, and trauma, religion and spirituality may offer helpful ways of thinking,

activities that enable different emotional experiences, interpersonal support networks, and sources of meaning. Another point of connection between psychotherapy and religion focuses on the relationship between the person and the religious/spiritual dimension of their life. This can comprise a thread within a broader personal issue, such as marital tensions that include, but are not restricted to, each spouse having a different religious background or attitude to spirituality. Alternatively, the personal meaning of religion and spirituality may take centre-stage in some therapies, for example in therapy with people who are trying to leave a religious cult or have been sexually abused by a priest. A further area that has received considerable attention in the counselling and psychotherapy literature has been the spirituality, faith, or religious affiliation of the therapist, or of organisations that offer therapy.

The following sections provide an introduction to some of the most influential forms of spiritually informed therapy. These elements may be combined in many different ways. It is perhaps important to keep in mind, when reflecting on these possibilities, that these activities do not comprise standard therapy practice. A study carried out in the United States by Rose et al. (2008) found that half of the clients in their survey, conducted in a number of typical community counselling services, expressed a wish to talk about religious and spiritual issues in their therapy. These people were not particularly religiously inclined – their overall levels of religious affiliation were significantly below the norm for the USA. Although research is not available, it is highly unlikely that religious or spiritual topics are addressed in anything like half of all therapy encounters. At the same time, 17 per cent of the clients in Rose and colleagues' (2008) survey stated a clear preference *not* to talk about religious or spiritual issues. In a survey in Germany, therapists reported that only 22 per cent of their clients wished to explore religious or spiritual issues in therapy (Hofmann and Walach 2011). These findings highlight the tension that exists within the field of spiritually informed therapy: for some clients, this is an area of great significance, while for others it is an area that holds no relevance or may even be something that they would actively seek to avoid. The competent use of such interventions needs to include a capacity to determine their appropriateness in each individual case.

## Religion and spirituality as a resource

Usually, religion or spirituality emerge as an issue in therapy when a client talks about spirituality or religious observance as a resource for coping and a source of positive meaning. Research that has invited people who are in a process of recovery from, for example, depression (Wilson and Giddings 2010), sexual abuse (Grossman et al. 2006), and intimate partner violence (Mahoney et al. 2016), typically report that spiritual or religious activities play a central role in healing. In one major psychotherapy outcome study, Arnette et al. (2007) found that enhanced spiritual well-being was a central element of improvement in therapy for suicidal African-American female survivors of intimate partner violence.

There are significant barriers to the exploration of religious and spiritual concerns and resources in therapy. In a large-scale survey of psychotherapy clients in Germany, Grosse Holtforth and Grawe (2002) found that fewer than 5 per cent of the clients explicitly mentioned at the start of therapy that exploring religious or spiritual issues was a therapeutic goal. This evidence suggests that the way that therapy is presented to clients may lead them to assume that it is not a context in which discussion of matters around religion and spirituality is either encouraged or welcomed. Knox et al. (2005) interviewed clients who had received therapy in community counselling agencies that did not advertise a specific religious or spiritual orientation. Some of these clients reported that it had been helpful for them to talk about everyday religious or spiritual issues, such as in relation to a bereavement; however, in each case, the topic had been initiated by the client rather than the therapist. The clients in this study reported that they had no knowledge of the religious or spiritual affiliation or interest of their therapists. As a result, on occasions when they had found it unhelpful to explore a religious or spiritual issue, or had refrained from doing so, they reported that the main reason had

been that they felt (or feared) an air of criticism or judgement on the part of the therapist. Cragun and Friedlander (2012) and Jenkins (2011) documented many accounts of clients having their spirituality denied or even disparaged by their therapist.

A further perspective on the barriers between therapy and spirituality can be found in studies of people who have undergone mystical or transformational experiences in their everyday life (Friedlander et al. 2013; Ivtzan et al. 2011; Lancaster and Palframan 2009; Noble 1987; Schlarb 2007; Spilka and Cassidy 1992; Waldron 1998). Such experiences are reported by at least 75 per cent of the population (Hay 1979; Hay and Hunt 2000; Hay and Morisy 1978). Nevertheless, those who have undergone a transformational personal experience, and at a later date have been in therapy, generally report that their therapist has not been interested in these personally significant events.

Taken as a whole, research findings suggest that the potential value of religion and spirituality as resources for addressing problems that people bring to therapy is not acknowledged as widely as maybe it ought to be.



### Case study 18.1: The case of Mary – religiously enhanced CBT

General anxiety disorder (GAD) refers to a state in which a person is constantly worried about one thing or another. Unlike more specific anxiety problems, such as panic or health anxiety, the results of psychotherapy for GAD are not especially good. In many instances, this is because the person has suffered from anxiety for many years, and has built a whole identity and lifestyle around this way of being. The Calmer Life programme was designed as a religiously enhanced form of CBT for GAD, specifically aimed at older people (Barrera et al. 2012). Therapy followed a structured set of steps over a three-month period, based on individual sessions, psycho-education, and self-practice exercises. Clients were able to choose between non-religious and religiously informed versions of the learning materials and exercises.

Mary was a 65-year-old woman who had been taking anxiety medication for eight years (Barrera et al. 2012). She worked part-time, but constantly worried about her health, finances, relationships, and personal safety. At the start of therapy, her scores were well above the clinical cut-off score on measures of anxiety, worry, and depression. Mary opted for the religiously enhanced version of the programme. Examples of the kinds of activities in which she participated included:

- focusing on a religious image or word during breathing exercises;
- keeping a 'blessings list';
- regularly saying a short prayer of gratitude to reinforce positive aspects of her life; and
- using statements such as 'I can't say for sure what will happen; only God knows what the future holds' to combat catastrophising.

By the end of therapy, Mary's scores were below the clinical cut-off, and these gains were maintained at six-month follow-up. Mary reported that the religious aspects of the CBT exercises had not only been helpful in relation to her symptoms, but had motivated her to attend Church more often.

The case of Mary provides a powerful example of the way in which a religious or spiritually informed approach can encourage client engagement in change processes by taking advantage of their preferences and pre-existing beliefs, while at the same time embedding therapy in a broader meaning system that has great significance for the person. In a subsequent case report, Ramos et al. (2014) described how this approach was used effectively with a client with non-mainstream religious beliefs drawn from several religious traditions.

## Therapy with members of specific religious faiths

An extensive literature exists on the issues associated with offering therapy to clients from different religious communities. For example, chapters in a comprehensive handbook compiled by Richards and Bergin (2014) discuss therapy with: Roman Catholics, members of Eastern Orthodox Churches, mainline Protestants, evangelical and fundamentalist Protestants, Pentecostal Protestants, Latter-Day Saints, Seventh-Day Adventists, Orthodox Jews, Conservative and Reform Jews, Muslims, Hindus, Buddhists, and individuals who follow North American Indian and Alaska Native spiritual teachings. Within each of these categories, it was also possible to identify further subgroups. By concentrating on the main religions that are represented in the USA, Richards and Bergin (2014) omit faith groups that are significant in other parts of the world, with the implication that their list of religious traditions could potentially be extended quite substantially.

It is not possible, in the space available here, to do justice to the complexity and depth of knowledge that a therapist might need when working with a client from each one of these traditions. Broadly speaking, it appears to be helpful to try to find some way of accommodating religious beliefs and values within the therapy by creating a ‘faith-adapted’ therapy for each client (Anderson et al. 2015). Sometimes this can be formalised into a named therapy approach, such as Christian counselling (McMinn et al. 2010) or the Qura’nic-based model of psychotherapy (Abu-Raiya 2015). In practice, however, it is extremely difficult to make a distinction between aspects of the client’s experience that refer to their religion and those that arise from their culture (Walpole et al. 2013). There is therefore a substantial overlap between the knowledge and skills required to undertake religion-adapted therapy and the competencies associated with culturally adapted and multicultural therapy (see Chapter 23).



### Case study 18.2: Talking about religion in a therapy group

The difficulties involved in talking about religion and spirituality, in a therapeutic setting that is not explicitly dedicated or advertised as focusing on such matters, can present complex issues in relation to therapist skills and decision-making. Wade et al. (2014) published a case analysis of how spiritual and religious topics were handled in a weekly therapy group, held in a hospital clinic and comprising members working on a range of personal problems. After the group had met for seven months, one of the members announced that she was leaving because she had been unable to talk about her spirituality – a crucial source of meaning in her life – during therapy. As a means of facilitating their own professional learning, Wade et al. (2014) carried out a detailed analysis of transcripts of audio recordings of all 28 sessions of the group up to that point. They found that, when a group member mentioned religion or spirituality, the response of the group leaders had the effect of diverting attention back to here-and-now processes, rather than forward into further exploration of religion/spirituality in the everyday life of the individual who had raised the topic. As a result, these conversations did not go anywhere, even though no one was responding in a manner that could be interpreted as overtly judgemental or excluding. Wade et al. (2014) offer reflections on alternative ways that the group co-facilitators might have responded at such moments. Their discussion of the implications of their findings carries considerable relevance beyond group therapy, and represents a valuable resource for individual, couple, and family therapists.

## Spiritual techniques in therapy

Spirituality may enter the therapy room in the form of the client describing and reflecting some kind of personally meaning spiritual episode that has occurred within their everyday life, or talking

about how religion or spirituality has helped them to cope with issues such as depression or anxiety. Some therapists report that the experience of moments of authenticity and connection within the routine process of therapy may possess spiritual meaning both for them and for their client (Burks and Robbins 2011, 2012; Steele 2014; Wong and Ng 2008). The experience of deep listening, reflection, and silence that can occur during therapy sessions, when client and therapist are present for each other in the moment, can create the conditions for spiritual emergence, without the need for any specific intervention technique to be deployed.

However, there are also many specific spiritually informed techniques and interventions that can be used within therapy sessions, or as a planned adjunct to therapy (Aten et al. 2011; Goldstein 2007; Pargament 2011; Walker and Hathaway 2013). These include: dream analysis, creating sacred objects or art-works, making space for sacred moments, fasting, transformational breathing, dance, drumming, prayer, promoting forgiveness, meditation, mindfulness, yoga, sacred writings, spiritual journaling, pilgrimage, time alone in nature, energy work, sweat lodges, and many other strategies. At the present time, the most clearly articulated and widely used approach to use spiritually informed techniques and interventions is transpersonal psychotherapy.

## Transpersonal psychotherapy

Transpersonal psychotherapy is a broad therapy approach that encompasses many strands of spiritual practice (Friedman and Hartelius 2013; Hillman 1977; Rowan 2005). Key influences on the emergence and development (Daniels 2013) of this form of therapy have been Carl Gustav Jung (1875–1981), George Gurdjieff (1966–1939), Roberto Assagioli (1888–1974), Stanislav Grof (born 1931), and Ken Wilber (born 1949). Hartelius et al. (2013) identify three central themes within the approach:

- 1 A psychology of self-expansiveness, reflected in a belief that levels of consciousness and self exist in which individual boundaries dissolve.
- 2 A whole-person orientation that views spirituality as an essential aspect of life.
- 3 An interest in transformative processes that enable the person to shift out of and beyond routine or everyday forms of functioning.

In relation to mainstream approaches, transpersonal therapy shares an appreciation of the significance of the unconscious with the psychodynamic tradition, and the importance of the idea of growth and actualisation with humanistic counselling. It also has many points of connection with the topic of meaning-in-life, which straddles all therapy orientations. Dialogue and research around transpersonal themes are supported by a set of specialist journals, including the *Journal of Transpersonal Psychology*, *Transpersonal Psychology Review*, *International Journal of Transpersonal Studies*, and *Journal of Transpersonal Research*. Transpersonal topics are also explored in the *Journal of Humanistic Psychology*, the *Humanistic Psychologist*, and *Journal of Humanistic Counseling*. Well-established transpersonal psychotherapy training programmes are available in most countries.

An important aspect of transpersonal psychology and psychotherapy has been a sustained effort to synthesise, and make accessible to contemporary readers, the traditional spiritual knowledge that is embedded in all world religions (Armstrong 2006). This endeavour has yielded a range of theoretical formulations around the nature of spiritual growth, such as in the work of Wilber (2000, 2006) and Assagioli (1991, 1993). Daniels (2013) suggests that each of these models tends to be based on one of three underlying metaphors: height (enlightenment), depth (individuation), or breadth (participation).

The body of work associated with Ken Wilber has been particularly influential. Although his ideas are complex and have continued to evolve over several decades, he has consistently emphasised the existence of a continuum of consciousness, based on the position that everyday consciousness is grounded in dualities such as mind–body or inner–outer, with more advanced levels being



marked by a weakening of such dichotomies (Combs 2013). It is important to note that Wilber's writing is not limited to psychotherapy but encompasses all aspects of social and individual well-being (Wilber et al. 2008).

As a more explicitly psychotherapeutic approach, the psychosynthesis model developed by Assagioli draws heavily on the ideas of Jung (Lombard 2017; Vaughan 2013). Although psychosynthesis is associated with the development and use of specific therapeutic techniques such as guided visualisation, daily self-reflection, role-play, imagery, storytelling, free-drawing, and dream work, it also offers a distinctively transpersonal conceptualisation of the notion of 'will', and places a strong emphasis on the importance of the therapeutic relationship.

A distinctive aspect of transpersonal psychotherapy practice is to encourage clients to take part in spiritual activities outside of therapy sessions. For example, Boorstein (2000) describes how he suggests to clients that they join prayer or meditation groups, read spiritual texts, and participate in retreats or a pilgrimage. Miller (2015) provides a detailed account of the work of one of the leading figures in psychotherapy in Scotland, Winifred Rushforth (1885–1983), who established the Davidson Clinic in Edinburgh where clients not only could receive psychotherapy but also be involved in a range of groups dedicated to different forms of Christian and New Age spiritual practice. Compared with other approaches to therapy, transpersonal psychotherapy has the advantage of being able to draw on a wide interest in spirituality within the community as a whole.

Recent developments in transpersonal psychology and psychotherapy include attempts to take account of feminist spirituality, and to establish links with neuropsychology and positive psychology (Daniels 2013).



### **Case study 18.3: The case of Tom – exploring transpersonal themes in brief transactional analysis psychotherapy**

The case of Tom provides an account of 18 sessions of transactional analysis psychotherapy with a gay man in his early 30s who was HIV-positive, had undergone the loss of his mother and his partner, and was experiencing high levels of depression and anxiety (Nuttall 2002). Although the topic of spirituality was mentioned by Tom in his third session, it did not become a core theme until the closing phase of the work. The early phase of therapy had been largely oriented around becoming more aware of how he sought to please other people, in his daily life as well in the therapy room. A growing appreciation of the memories, needs, and feelings that underpinned these interpersonal patterns made it possible for Tom to continue to explore, between sessions, his sense of self. A comment that the flat in which he was currently living was 'soulless', encouraged a thread of reflection and therapeutic conversation into the meaning of 'soul'. At this point, he reported that, while he was aware of an 'old' self (the people-pleaser) and a new self that was building a different life, he was also starting to be more aware of a third self, that in some way looked down on both of these selves. He made connections between this emergent self and memories of transcendent experiences as a child floating on the sea and looking up at the sky. Nuttall (2002) observed that he, himself, experienced a sense of floating at these moments when Tom was talking about such memories. At the end of therapy, Tom appeared to have become able to use this spiritual or 'soul' part of his inner experience as a guide for future action.

This case example offers a way of understanding how a therapist without specific training in a transpersonal way of working could nevertheless use standard psychodynamic technique to support a client through a process of accessing, and then making use of, a transcendent dimension of experience.



## Therapist attitudes and competence in working with religious and spiritual issues

The extent to which religious and spiritual perspectives are addressed in therapy is crucially dependent on the person of the therapist. In some areas of therapy practice, the beliefs or worldview of the therapist is not a major factor. For example, therapist choice around whether or not to use techniques such as feedback scales, relaxation exercises, or homework tasks does not raise fundamental values issues. By contrast, the spiritual and religious beliefs and attitudes of a therapist are likely to have a significant influence on whether they are responsive to these themes when presented by a client.

In a survey of therapists in Germany, 57 per cent described themselves as being either religious or spiritual (Hofmann and Walach 2011). In a similar survey carried out in the USA, Canada, and New Zealand, Smith and Orlinsky (2004) found that 51 per cent of therapists described themselves as spiritual at a personal level, while an additional 27 per cent reported that their spirituality was channelled through membership of a religion. The remaining 22 per cent described themselves as non-religious. In a survey of explicitly spiritual therapists, Ross (2016) was able to identify distinctive subtypes of spiritual orientation.

The intensity and type of religious/spiritual affiliation appear to make a significant difference to what happens in therapy. For example, in a study of counsellors who defined themselves as committed, practising Christians, Evans (2003) found that, while most respondents believed that they were able to accept gay and lesbian clients, a minority who adopted a literalist view of the Bible were judgemental about perceived gay/lesbian behaviours. In a review of research into therapist spiritual/religious attitudes, Cummings et al. (2014) found that therapists who described themselves as religious were less accepting of gay and lesbian sexuality. The same authors also found that non-religious therapists were reluctant to explore religious and spiritual issues with clients. Wyatt (2002, 2004) has described the depth of reflection undertaken by psychodynamic psychotherapists to achieve a workable integration of their religious and psychotherapeutic beliefs and values. The challenges associated with reconciling Christian faith with the views of non-Christian clients has been explored by Scott (2013).

The overall picture that emerges from studies of therapist attitudes and behaviour around working with spirituality is that a significant proportion of therapists tend to experience this aspect of their work as problematic. In interviews with experienced therapists, Magaldi-Dopman et al. (2011) found that their respondents expressed high levels of conflict over how to respond to clients who presented religious and spiritual issues, and believed that their training had not prepared them sufficiently to handle such issues. Similar findings have been reported by Jafari (2016). In a survey of therapists in the USA, Frazier and Hansen (2009) found high levels of agreement around what therapists 'should' do in respect of this area of practice. For instance, therapists in their survey indicated that it was important to use strategies such as 'actively communicate respect for clients' religious/spiritual beliefs', 'evaluate when one's religious/spiritual values and biases negatively impact on treatment', and 'use clients' religious/spiritual strengths in treatment'. However, these therapists also acknowledged that they actually did this relatively infrequently.

Some therapists are troubled by ethical issues associated with this area of their work. For example, it can be hard to know how to handle the process of informed consent, in respect of introducing a spiritual or religious perspective into therapy with a client, make decisions around boundaries in relation to how much of one's own religious affiliation to disclose, or be clear about the limits of one's professional competence (Barnett and Johnson 2011; Hathaway 2011; Knapp et al. 2010). Some spiritual practices may be illegal – for example, using drugs to achieve altered states of consciousness.

In conclusion, questions remain about the kind of support, training, and supervision required for therapists to feel more competent and confident in working with clients around spiritual or religious issues. One idea that has received some attention in respect of this matter involves models of collaboration between therapists and clergy (Breuninger et al. 2014; Harborne 2012).

## The dark side of religion and spirituality

Most people's view of religion and spirituality is that these domains represent enormously potent and supportive sources of meaning. At the same time, it needs to be recognised that individuals can be damaged by their involvement in religion and spirituality, and that some clients may seek therapy in order to come to terms with, distance themselves from, eliminate, or recover from this aspect of their life. There are two main ways in which religion and spirituality may be damaging. First, religious and spiritual groups can sometimes function as tightly-knit social systems in which high levels of control are exerted by those in charge, with the consequence that individual diversity and freedom of thought may be suppressed or even punished. Second, religion and spirituality are typically grounded in faith: the belief that certain truths are valid and beyond question. It is clear that dialogue, debate, and questioning thrive within theology and among many individuals with strong religious and spiritual beliefs. Nevertheless, there is a sense in which religious and spiritual truths are immune to rational argument, by dint of being based on direct experience of a higher power or a particular spiritual technique such as prayer, fasting, or meditation. These dimensions of religion and spirituality – social control and cognitive certainty – can co-exist in many settings, and can cause significant emotional and relationship difficulties for those whose preferred life path leads them in a direction of not conforming to a religious or spiritual system in which they have been brought up, or in which they have become involved.

One way in which religion and spirituality can be a barrier to therapy, and potentially harmful to a client or patient, is what Clarke et al. (2013) have described as 'spiritual bypass'. They use this term to characterise a process in which a client makes sense of their problems purely in spiritual terms, and is not willing to deal with psychological or psychosomatic symptoms that are having a negative effect on their life. Clarke et al. (2013) provide the example of a young woman who came to therapy to explore her spirituality, with a counsellor who was known to be open and well-informed about spiritual issues. Fairly quickly, it became apparent that she exhibited high levels of anxiety and was struggling to cope with several addictions. On further questioning, the client reported that she had been sexually abused by her father, but had used religious and spiritual guidance to forgive him, so did not need to work on that issue. From the perspective of the counsellor, it seemed as though the client would only be able to live a more satisfying and productive life if she dealt with the emotional consequences of the early trauma that she had undergone. Clarke et al. (2013) describe how motivational interviewing strategies (see Chapter 8) were used with this client to acknowledge, accept, and honour her spirituality, while creating a space within which the value of an alternative (psychological) approach could be contemplated and eventually implemented. While other therapists might not know about motivational interviewing, they would be familiar with the kind of therapeutic process that occurred in this case, in which a conversation needed to take place around the relative balance between a spiritual and psychotherapeutic orientation to the problem. The implication in this case was that the client might well have continued to have a troubled and unproductive life if she had persisted with an 'untreated' psychological problem. The kind of situation described by Clarke et al. (2013) also serves as an example of a moment in therapy when pro- or anti-religious therapist views might make a big difference to what happened next. A therapist who understood the client's spirituality as resistance to insight, or a defence, or even as a symptom of psychotic thought disorder, would have been unlikely to have made much progress with this client.

Although research has not been carried out into the prevalence of 'spiritual bypass', it seems reasonable to conclude that it does exist, and that it is an example of the potential harmfulness of religious beliefs. Of course, the reverse is also true: an unknown proportion of clients could be defined as suffering from a 'psychological road-block' that stops them from making use of religious and spiritual resources that could transform their lives.

There is considerable evidence of the harmful effects of institutional, organised religion. Oakley and Kinmond (2013) have advocated that the phenomenon of spiritual abuse should receive wider recognition, in order to make it easier for people who have been psychologically and emotionally

controlled by religious organisations to gain effective support. In addition to those who may have been emotionally abused, there are many individuals who have been sexually abused by clergy (Blakemore et al. 2017; Fater and Mullaney 2000; McLaughlin 1994; Terry 2008; van Wormer and Berns 2004). The depth of social, emotional, and cognitive impact of such crimes is poignantly expressed in testimonies collected by van Wormer and Berns (2004). Gender roles and attitudes to women that are associated with major world religions have been found to be associated with violence against women (Johnson 2016). Membership of a religious sect or cult has been shown to have a lasting negative impact on mental health and well-being (Dubrow-Marshall and Dubrow-Marshall 2015). Beyond these specific areas of institutional religious violation of basic human rights, there are individuals who feel that, at a personal level, it is necessary for them to leave their religion – a choice that may entail a re-organisation of their whole way of life (Winell 2006).

A final category of harmful religion-informed therapy relates to interventions designed to ‘convert’ individuals who are gay, lesbian, bisexual, or transgender – so that they become either celibate or heterosexual. This practice is explicitly deemed to be unethical by most counselling and psychotherapy professional associations, worldwide. There have been, and still are, counsellors and psychotherapists who make a living by promising to ‘cure’ people of their homosexual desires. A study by Beckstead and Morrow (2004) of the experiences of 42 men and women in Utah, USA (a strongly religious community) who had undergone ‘conversion therapy’, and the ensuing debate (Gonsiorek 2004; Haldeman 2004; Miville and Ferguson 2004; Morrow et al. 2004; Phillips 2004; Worthington 2004), illustrate some of the complexities of this issue. Beckstead and Morrow (2004) found that none of the participants in their study reported that their basic pattern of sexual desire had been changed as a result of therapy. On the other hand, about half of the participants regarded their therapy as having been useful for them, in enabling them to accept a heterosexual lifestyle. These findings are consistent with the results of previous research into sexual reorientation/conversion therapy (Shidlo and Schroeder 2002; Throckmorton 2002). However, debates about whether such treatment is effective or otherwise distract from the main issue, which is whether it is ethical (Drescher 2015). The personal accounts of individuals who have undergone conversion therapy (for example, Beer 2015; Levovitz 2015) reveal that people rarely make an autonomous choice to seek conversion therapy, but instead are pressurised by their religious community to do so.

## Conclusions

There is a general consensus within the profession that counselling and psychotherapy theory and practice are currently travelling in the direction of greater appreciation of the role of spiritual experience in people’s lives. Good ideas from spiritual practice, such as mindfulness techniques or relaxation methods based on yoga, are widely incorporated into mainstream therapy practice. It is clear that an enhanced place for spiritual dimensions has an important part to play in contributing to the adoption of a more strengths-oriented stance in therapy, the construction of forms of practice that enable people to address issues around their relationship with nature, and making mainstream approaches to therapy more attuned to the beliefs of people from ‘minority’ and indigenous cultural groups.

What is less certain is whether it is possible to engineer a more fundamental rapprochement at a theoretical level, in terms of arriving at a comprehensive model of religiously informed therapy. This issue need not represent a barrier to progress. Being able to use religious and spiritual practice and ideas in a pragmatic way to facilitate change is sufficient for most therapists and clients. The question of theoretical integration of religion into therapy can be viewed as a form of intellectual work occurring at the interface between two disciplines: psychology and theology. Similar challenges are associated with interfaces between psychology and other disciplines, such as biology and sociology.

There has been considerable research into the implementation of appropriately timed and focused religious and spiritual perspectives in counselling and psychotherapy. In addition to the

specific studies cited in this chapter, reviews of this research can be found in Cornish and Wade (2010), Kennedy et al. (2015), Post and Wade (2009), and Smith et al. (2007). These reviews consistently portray such interventions as helpful for clients.

Despite the growing integration of spiritual and religious perspectives into counselling and psychotherapy practice, it is clear that challenges remain in respect of therapist training and supervision around this topic. Looked at more broadly, these challenges may be unavoidable in a world characterised by fractured spiritualities (Tacey 2013). The great world religions and spiritual disciplines developed at times and in places where it was possible for people to be totally immersed in a particular belief system and set of rituals. Globalisation and ready access to information about alternative spiritual/religious systems means that it has become rare for anyone to exist within a 'sacred canopy' (Berger 1967). As a result, therapists and their clients struggle to find points of connection between the fragments of spirituality which each of them possesses.



### Topics for reflection and discussion

- 1 How significant is religion and/or spirituality for you in your own life? To what extent, and in what ways, do they help you to cope with stress, relationship issues, and emotional problems?
- 2 As a client or service user, how important is it for you to know about the religious and spiritual stance and experience of your therapist or helper? What difference does it make for you? What do you do to collect such information about your therapist?

### Suggested further reading

The *APA Handbook of Psychology, Religion, and Spirituality* (Pargament 2013) discusses a wide range of religious and spiritual topics, and draws on the writings of leading figures in this field to open up a broader debate in which to make sense of the issues discussed in the present chapter. *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred*, by Kenneth Pargament (2011), provides an introduction to how one influential spiritually oriented therapist works with clients. A paper by the British psychoanalyst and social critic Andrew Samuels (2004) offers some thought-provoking reflections on the merits and risks of spiritually informed therapy. Vieten and Scammell (2015) have compiled a pragmatic guide to the spiritual and religious skills and competencies required for effective therapy around such issues.

# Embodied conversations: implications of developmental neuroscience and other biologically informed perspectives

<b>Introduction</b>	<b>270</b>
<b>Embodied therapy: older traditions</b>	<b>271</b>
<b>Basic concepts</b>	<b>272</b>
<b>Applications</b>	<b>272</b>
Paying attention to bodily processes	273
Interventions that reflect a neurobiological perspective	274
<b>Theoretical perspectives</b>	<b>276</b>
<b>Risks of uncritical acceptance of a neurobiological perspective</b>	<b>278</b>
<b>Conclusions</b>	<b>279</b>
<b>Topics for reflection and discussion</b>	<b>279</b>
<b>Suggested further reading</b>	<b>280</b>

## Introduction

Counselling and psychotherapy are fundamentally forms of helping that rely on conversation and dialogue. Generally, when a person enters therapy, they neither undergo a blood test or brain scan, nor are they prescribed medication. What they do, instead, is talk about what concerns them, work with their therapist to find new ways of making sense of what is happening, and generate potential

solutions that can then be tried out. The main areas of focus within therapy are what the person thinks and feels, how they act, and their relationships with others.

It has always been clear that this kind of predominantly cognitive and verbal way of doing therapy has significant limitations. It is clear that to be human involves having an embodied existence, and that the ways that people think and act are powerfully influenced by bodily states. Therapy that operates solely on the basis of 'talking heads' is missing crucial elements of human experience.

The aim of this chapter is to explore those areas of biology and neuropsychology that have made a positive contribution to the development of more effective therapy techniques and interventions. Due to limits of space, there is no attempt to explain in detail the underlying scientific evidence that exists in this field of inquiry. Instead, the chapter focuses on how therapists have drawn on biological and neuropsychological knowledge to inform their work with clients.

The chapter is organised in four main sections. First, there is an acknowledgement of older therapeutic and healing traditions that have made use of embodied insights. Attention then turns to two aspects of current practice: biological perspectives on client problems, and biologically or embodied dimensions of the process of therapy. The chapter ends with an examination of the potential risks of uncritical over-emphasis on biological approaches to problems in living.

## Embodied therapy: older traditions

In his fieldwork with the central African Ndembu tribe in the 1950s, the anthropologist Victor Turner observed the process through which a local witch doctor worked with a member of the community who was anxious, depressed, and socially isolated (Turner 1964). In this classic ethnographic study, Turner reported that the whole community became involved in a prolonged ritual that involved drumming, dancing, chanting, the sacrifice of a goat, and the ingestion of mood-altering herbal remedies. In amongst all this, the 'client' was encouraged to share his feelings, and was provided with an explanation (spirit possession) for his problems, in the context of a therapeutic alliance with the healer. What comes across is a depiction of a massively embodied cultural event that incorporates a therapeutic process with which any Western therapist would be familiar, alongside a set of physical activities that appear to be quite strange.

The case of the Ndembu witch doctor involves embodied therapeutic activities such as trance states, repetitive physical movement, and ingestion of mind-altering substances, which have been central elements of healing rituals for millennia (Bourguignon 1979). These practices have persisted, both within modern-day psychotherapy and in everyday culture. Wilhelm Reich, an influential follower of Freud, developed a form of psychotherapy that sought to use body movement to release emotional energy that was locked up in muscle groups. This model of therapy still exists in the form of bioenergetics and other body therapies (Lowen 1994; Marlock and Weiss 2016). Many people who are not psychologists or psychotherapists believe in the value of such activities as physical exercise, yoga, dance, and change of diet as ways of dealing with emotional problems (Jorm et al. 2000), and in the efficacy of mind-altering, non-prescribed recreational or street drugs (Greenberg 2010).

What is relatively new are advances in neuroscience (neuropsychology and neurobiology) that have created a wealth of knowledge around biological processes, the brain, and nervous system associated with cognition, emotion, and relationships. These discoveries have built on long-established cultural beliefs and practices, as well as drawing on the prestige and objectivity of science. As a result, they have had a deep, wide-ranging, and growing influence on psychotherapy research and practice. Brain scanning and imaging, and the tracking of biochemical processes, have allowed researchers to get to the position where biological knowledge can be used to inform counselling and psychotherapy practice. Acquiring an understanding of brain function is becoming increasingly important for therapists, both as a means of possessing a richer and more holistic perspective on



the person, and as a source of ideas around specific therapeutic strategies for clients with particular kinds of problems. Being able to develop a critical appreciation of neurobiology and its implications for therapy is not an easy task because of the technical complexity involved. Coverage of this topic here makes no claim to be comprehensive. Instead, the intention is to provide an introduction to some of the key themes and issues within this domain.

## Basic concepts

The application of neuroscience in therapy needs to begin with an understanding of some basic aspects of brain functioning. Diagrams of brain structure tend to emphasise two key features. Vertically, the brain can broadly be divided into the limbic system, situated at the base of the brain and top of the spinal cord, which is covered by the cortex – a large area that fills most of the skull. Horizontally, it can be seen that the cortex is divided into two hemispheres. The role and functioning of each of these parts of the brain, and the way they interact with each other, are highly complex. Nevertheless, it is possible to identify certain functions that are primarily located in certain areas. The limbic system is the ‘old’ (in evolutionary terms) part of the brain. It deals with rapid emotional reactions to events, for example the activation of the ‘fight–flight’ response. The cortex, by contrast, is a more recent evolutionary development, and deals with thinking, language use, and conscious control and planning. Within the cortex, each hemisphere broadly specialises in a different function. The left hemisphere controls the right hand and the right side of the body, and the use of language. The right hemisphere controls the left hand and left side of the body, and specialises in processing information in terms of images.

Another important aspect of brain functioning, from a psychotherapeutic perspective, is the existence within the cortex of ‘mirror neurons’. Neurons are the basic cell-level ‘building blocks’ of the brain. Mirror neurons seem to have a specific function of replicating, in one individual, a pattern of action being observed in another individual. For example, very young babies will smile in response to a smile directed at them, from someone in their field of view. It is clear that a baby is not capable of consciously interpreting the meaning of a smile. What seems to be happening is that an automatic neural response is triggered. The significance of mirror neurons is that they demonstrate that sensitivity to relationships with others is an integral part of the way that the brain works.

Further information on these topics can be found in introductory neuroscience texts, written for therapists, such as Montgomery (2013) and Siegel (2012). Shorter, article-length accounts are available in Siegel (2006, 2009) and Oliver and Ostrofsky (2007).

The significance of neuroscience for therapy lies in the fact that certain possibilities and tendencies are ‘hard-wired’ into the physical fabric of human beings. These biological structures shape how human beings respond to different types of situations. They do not *determine* how a person will respond, because there is a certain amount of plasticity in the brain and nervous system, which results in a capacity to ‘work around’ these structures and establish alternative pathways (Doidge 2007). Human beings also have capacity to be selective in what they attend to and what they do, which results in a multiplicity of strategies for modifying or regulating basic neural processes. However, in the end, plasticity and choice operate in relation to fixed parameters. It is possible to move the furniture around in many different configurations – but it is still the same furniture in the same room, and it still needs to be able to provide somewhere to sit down.

## Applications

There are many ways in which knowledge of neurobiology can be useful to therapists. Essentially, neurobiology acts as a reminder that clients (and therapists) are embodied entities as well as being cognitive and linguistic entities.

## Paying attention to bodily processes

The simplest way in which a therapist can take account of bodily processes is to be observant and curious around the possible meaning and significance of what they can see, hear, and feel in the therapy room. Much of this can be understood in evolutionary terms – over millennia, there has been survival value in human beings evolving biologically ‘wired-in’ signalling systems through which distress can be conveyed to others, either as a trigger for the delivery of altruistic support or as a warning sign for others to flee from danger. In addition to these hard-wired signalling systems, different cultures have developed strategies for concealing or controlling the transmission of such information. For example, styles of clothing and facial make-up are ways of hiding bodily signals. Paying attention to bodily processes is potentially useful for therapists because it makes it possible to access valuable information about the person’s true reactions to situations. Examples of this way of working in therapy are briefly summarised below.

*Breathing.* The breathing patterns of both client and therapist are an indicator of emotional states. The rate at which oxygen is taken into the lungs has an effect on the amount of carbon dioxide in the body, and on stress hormones. The physical signs associated with these processes, such as palpitations, may be interpreted as catastrophic, leading to a panic reaction. Shallow breathing exacerbates anxiety and panic, while breath-holding is often a sign of an attempt to control painful or terrifying emotions. On the other hand, deep breathing into the abdomen can produce energy and a sense of positivity. The relevance of ‘breath work’ in counselling is discussed by Young et al. (2010), and is central to the use of yoga and other movement interventions that may be used as an adjunct to therapy.

*Voice quality.* The way that the client or therapist talks, expressed through the tone, pace, and volume of their voice, has been shown to be a significant factor in therapy (Rice and Wagstaff 1967; Tomicic et al. 2015). For example, Rice and Wagstaff (1967) observed four distinctive patterns of client voice quality: emotional, focused (tracking inner experience), externalising (directing or controlling the listener), and limited (holding back). These different voice qualities convey information about how the person is regulating and expressing their emotions, while at the same time maintaining closeness/distance in their relationship with their interlocutor (the therapist). In turn, the therapist may exhibit voice qualities such as soft (interpersonally intimate and tuned in to the client’s feelings) or natural (indicating interest and attentiveness). Alongside its possible cultural meaning (e.g. the therapist speaking like a teacher, or like a mother trying to soothe her baby), voice quality has a neurobiological dimension. For example, it has been shown that when the therapist uses a soft, soothing voice, it produces shifts in autonomic functioning in the client (Kykyri et al. 2017). It is likely that responsiveness to voice quality was evolutionary advantageous, and is therefore biologically based. While clients and therapists have an awareness that different vocal qualities are meaningful (Tomicic et al. 2015), it is probable that most of the time they are not consciously paying attention to such information. It therefore functions out of awareness, a channel of embodied communication between client and therapist.

*Facial expressiveness.* Within the field of social psychology, it has long been considered that there exist a complex set of micro-facial expressions that occur out of awareness and function as a social signalling system (Ekman and Friesen 1978). Studies have found that these micro-movements are culturally universal and grounded in autonomic nervous system activity (Ekman 2003). Facial micro-movements are highly significant in therapy and in many other social situations such as marriage and work because they act as a channel of communication for emotions, such as disgust and anger, that a person might be consciously trying to suppress. However, there is evidence that the other person may react to these cues at a neurobiological level, even if they are not able to verbalise their response. In addition, accuracy in understanding subtle facial movements is associated with an inability to manage social interaction. Therapy researchers have identified a number of patterns

of client–therapist facial interaction patterns, associated with productive and unproductive therapy processes and episodes (Benecke et al. 2005; De Roten et al. 2002; Rasting and Beutel 2005).

*Tummy rumbling.* Although it is usually considered as an indicator of digestive functioning, such as being hungry, tummy rumbling has also been shown to function as an expression of the personal and emotional significance of whatever is happening at the present moment in a relationship (King 2011; Raymond 2017). Pollock (2014) describes this as the functioning of the ‘gut brain’.

*Other physical signs.* A flushed face or agitated movement may indicate that the client is close to being aware of emotional states that have long been suppressed (Minton et al. 2006; Ogden and Fisher 2012; Ogden and Minton 2000). Tears (Blume-Marcovici et al. 2015), yawning, and sighing represent other important embodied and biologically hard-wired channels of communication that may play a significant role in the process of therapy.

*The therapist’s own bodily response.* A key skill for any therapist is to be open to and observant of their own bodily reactions, at the same time as observing the non-verbal information conveyed by the client. For example, a therapist may note that they are moving around in their chair, are locked into a particular facial expression, or that their tummy is rumbling. Different therapy approaches place varying levels of significance on these responses.

*Experiential focusing.* The technique of experiential focusing is widely used in person-centred and humanistic therapies as a means for client and therapist to explore the meaning of internal bodily states of feeling (see Chapter 10).

## Interventions that reflect a neurobiological perspective

There are many therapy approaches that specifically focus on somatic or bodily intervention (Heller and Duclos 2012; Marlock and Weiss 2016), in the sense of inviting the client to move in a particular way, pay attention to a bodily state, or change their diet, rather than just talking. Similar interventions are found in yoga and other traditional healing systems, and many of the biologically and body-oriented techniques used by contemporary therapists represent adaptations of these older sources of knowledge and wisdom.

*Eye movement desensitisation and reprocessing (EMDR).* The technique of EMDR (Shapiro 2001) has been devised to activate both hemispheres of the brain at the same time, as a means of facilitating the cognitive assimilation of traumatic memories that have been ‘trapped’ or stored as terrifying visual and sensory images.

*Meditation and mindfulness.* There exist a wide range of techniques that are based on strategies for slowing down thought processes through posture and breathing (and sometimes movement). Methods such as mindfulness and meditation have been existed for many years within Western and other spiritual traditions, and have been widely integrated into a range of contemporary approaches to counselling and psychotherapy. There is substantial evidence that the effectiveness of these techniques is due to shifts in neurological function that become established on a more or less permanent basis in anyone who practises them regularly (Perestrelo and Teixeira 2016; Schmidt and Walach 2014).

*Psychopharmacology.* A key facet of neurobiology that therapists need to understand is psychopharmacology. Many clients who make use of therapy also take prescribed medication to control anxiety, depression, or mood swings. Further information about this topic can be found in Daines et al. (2007), Gitlin (2007), King and Anderson (2004), Patterson et al. (2009), and Sinicola and Peters-Strickland (2011). Issues and possibilities arising from the combined use of counselling/psychotherapy

and antidepressants are discussed by Feldman and Feldman (1997), Petersen (2006), and Sparks et al. (2006).

*Lifestyle interventions.* There is extensive evidence that a healthy diet, regular exercise, avoidance of toxic physical environments (e.g. noise, pollution), and interaction with dogs and horses, each has a positive effect on health and well-being, due to the neurological and other biochemical effects of such activities.

*Being in nature.* Spending time indoors has been found to be intrinsically stressful for people (Ulrich 1981), because it requires focused visual attention on short distances that is contrary to evolutionary needs. By contrast, time spent outdoors has a healing or de-stressing effect. In addition, there appears to exist an evolutionary predisposition towards preferring environments that are perceived as non-threatening and which were historically important for survival (i.e. that offer food and water). As a result, exposure to natural outdoor environments triggers a number of positive biological effects such as increased positive emotion, reduced negative emotion, reduced physiological arousal, and a decreased stress response.

*Movement.* The action of physically moving one's body has a significant effect on many aspects of brain function and emotional experience (Shafir 2016). The use of movement is a therapeutic strategy that is central to established psychotherapeutic approaches such as body therapy, dance and drama therapy, equine-assisted therapy, and outdoor therapy. A neurobiological perspective also allows an appreciation of the psychotherapeutic effects of movement-based activities such as self-defence training (Rosenblum and Taska 2014) and shamanic ritual (Flor-Henry et al. 2017).

*Sleep interventions.* It is now widely believed that insomnia is a hidden but significant aspect of many of the problems that many people bring to therapy. A person who is anxious will almost certainly find it hard to sleep, because they continue to ruminate over stressful incidents, or feel bodily tension, rather than allowing themselves to relax, let go, and enter a deep sleep. This in turn has further effects. Sleep deprivation makes it hard for the person to concentrate, and they may become unhappy and irritable. Dysfunctional sleep patterns are hard to shift, and may persist even when a client has made important progress around other issues. Attention to sleep difficulties therefore represents a straightforward form of neurobiological intervention that can have major benefits in therapy. At its simplest, this can involve inviting the client to talk about sleep issues, as a means of working out their own solutions. Beyond that, there are valuable self-help resources available, brief CBT sleep interventions, and specialised sleep clinics.

*Taking account of specific health conditions.* There are specific conditions from which clients may suffer that have a major neurological component, such as brain injury, Asperger's syndrome, and Alzheimer's disease. Therapists who work with such clients may find it valuable to develop an understanding of how neurological factors may have an impact on their client's behaviour and emotions. Many other illnesses and diseases can shape the emotions, thought processes, and relationships of clients in ways that might also impact their therapy.

### Box 19.1: The experience of taking antidepressants

Research into clients' experiences of using antidepressants acts as a reminder that the impact of biological processes (such as changing brain chemistry through medication) on human behaviour is usually shaped by the meaning that the person attributes to the biological event. Garfield et al. (2003) interviewed people who had taken antidepressant medication to treat their depression.

Almost all of them talked about ways in which the meaning of taking the drug influenced their recovery. For example, deciding to take medication helped some individuals to feel that they were taking control of their problems. For other participants in this study, taking an antidepressant was associated with a sense of shame and stigma that impeded their recovery. Similarly, in a study of experiences of women in New Zealand around taking antidepressant medication, Cartwright et al. (2016) found that many of them used the effect of the medication to 'kick-start' new initiatives around ways of coping and relating to others. The strength of these types of reaction to antidepressant use is so significant that Ankarberg and Falkenstrom (2008) have suggested that what taking the medication means to the person may have more of an effect than the actual pharmacological action of the drug itself. They suggest that prescribing an antidepressant should be regarded as a psychological intervention as well as a pharmacological one.

## Theoretical perspectives

At the present time, there is no unified theory of the psychobiology of therapy. Instead, various researchers have developed models that make links between specific aspects of brain functioning and related aspects of therapy (or everyday processes and experiences that are relevant to therapy).

*Trauma theory.* At a general level, many therapy approaches reflect a position that 'the body remembers' (Rothschild 2000) – the effort to maintain self-control in the face of emotionally threatening experiences leads to a variety of types of stress in the body. When a person arrives at a point in their life when they wish to confront these memories, and come to terms with them, the concomitant body 'armouring' begins to fragment, which is manifested in many different types of bodily symptom (van der Kolk 2006). A further aspect of the neurobiology of trauma is concerned with the way in which emotionally overwhelming experiences are processed in memory (Lane et al. 2015).

*Embodied cognition.* Within psychology and psychotherapy, and for most ordinary people, thinking is assumed to be a process that involves inner speech and images. What has become apparent, through neurobiological research, is that cognitive processes are associated with the activation of sensorimotor areas of the brain that also serve to control bodily movements (Claxton 2015). For example, what seems to happen when a person reads something, or responds to a verbal request, is that the words are translated into non-verbal micro-actions such as hand movements. Summing up this process, Claxton (2012: 80) argues that the brain's default response is to 'get you set to do something'. In relation to therapy, this idea opens up the possibility that attention to bodily states and movements can facilitate the effectiveness of the kind of complex personal problem-solving that forms a necessary aspect of coming to terms with problems in living. It also explains why clients who are too fluent and articulate may benefit less from therapy than those who talk more slowly, in a way that takes account of their momentary feelings about the topic being explored (Claxton 2012). It is possible that the capacity to move about while exploring personal issues may be a distinctive therapeutic advantage for approaches such as outdoor therapy (see Chapter 17) and dance therapy (Hanna 2014).

*Polyvagal theory.* Most people are familiar with the idea that threat triggers a 'fight-flight' response. The evolutionary and neurobiological basis for this model is well established, in terms of the pathways that link perception of threat with the release of adrenaline. Recently, further research by Porges (2014) has drawn attention to the significance of the vagal system, which is involved in the regulation and coordination of heart rate, sucking, swallowing, digestion, vocalisations, and breathing. This work has identified a broader set of functions. Fight-flight is part of a general 'mobilising' function. There is also a 'safe and social' function, associated with the capacity for relaxed and



playful interaction with others, and an ‘immobilised’ state, in which the person is frozen and ‘plays dead’ or enters ‘survival mode’. This latter state would have had an evolutionary advantage in terms of hiding from predators, and is located in the ‘oldest’ area of the nervous system. In his ‘polyvagal theory’, Porges (2014) conceptualises these functions as a continuum or ladder, and suggests that it can be helpful for therapists and clients to use these ideas to identify and understand how and why the client moves between different states of being associated with each of these nervous system functions. On the basis of this research, the idea of the ‘window of tolerance’ has become an important concept in therapy for clients who have experienced abuse and trauma (Corrigan et al. 2011; Ogden et al. 2006). The aim is to use the therapist’s healing presence to keep the client within an optimal arousal zone, encompassing both intense emotion and states of calm or relaxation, in which emotions can be safely tolerated (Geller and Porges 2014).

*Interpersonal synchrony.* Therapists and clients are usually aware of the potential significance of non-verbal behaviour in therapy. Important information is conveyed through smiling, posture, eye gaze, gesture, voice quality, and other non-verbal cues. These processes occur very rapidly and are out of conscious awareness. As a result, research in this area has largely comprised analysis of video-recordings of therapy sessions. This research has consistently yielded findings that support the therapeutic role of unconscious non-verbal information (Imel et al. 2014; Kleinbub et al. 2012; Ramseyer and Tschacher 2011). For example, in respect of smiling, different patterns of client–therapist smile interaction sequences can be observed (Benecke et al. 2005), with mutual, affiliative smiling consistently being associated with strong therapeutic alliances (De Roten et al. 2002). Rasting and Beutel (2005) found that, when a broad range of facial expressions was studied, cases in which the therapists reciprocated the client’s facial expression of emotion reported poorer outcomes than when the therapist followed the client’s facial cues and became too caught up in the client’s dysfunctional pattern of relating. Similar results were obtained by Reich et al. (2014) in a study of vocal synchrony. Tomasello et al. (2005) have argued that the capacity to coordinate emotional states and intentions has an evolutionary, biological basis.

A programme of research at the University of Jyväskylä, Finland, has started to look at the neurobiological basis of different forms of ‘embodied attunement’ (Seikkula et al. 2015). In these studies, clients and therapists are wired up to record key autonomic nervous system indicators: heart rate, respiration, and skin conductance. Sessions are video-recorded and participants are asked to watch the recording after the session, and comment on what they were experiencing at moments when significant unconscious bodily responses were being registered. Using this methodology, Karvonen et al. (2016) were able to identify different patterns of clinically meaningful embodied synchrony between clients and therapists. Itävuori et al. (2015) carried out a micro-analysis of key moments in therapy, and found on-going synchrony during periods of silence, with shifts in rate and depth of breathing being particularly closely aligned with emotional expressiveness. Kykyri et al. (2017) found that, at times when the client was expressing emotionally painful material, the use of a soft voice by the therapist could be observed to lead to changes in client arousal. The significance of these findings is that the methodology used in these studies was measuring subtle and ultra-brief movement in autonomic states that are not accessible to the conscious awareness of the client or therapist. Nevertheless, these embodied synchronous processes appeared to play a key role in both maintaining a therapeutic relationship and regulating emotions. An important emerging theme in this area of research is that high levels of client–therapist synchrony (as in a dance) are sometimes associated with helpful moments in therapy, but sometimes are not. There appear to be times when it is better for the therapist to decline the invitation to participate in the dance.

*Hemispheric functioning.* One of the first aspects of neuropsychological research to be applied in therapy relates to the functioning of the two hemispheres of the brain, whereby the left hemisphere ‘specialises’ in language and logical-linear analysis, while the right hemisphere is the location of visual and creative processing (McGilchrist 2012). This distinction has had a wide range of applications



in therapy, mainly relating to the goal of helping clients to engage in creative problem-solving and fresh thinking through free association, use of dreams, metaphors and imagery, and various art-based techniques.

### Box 19.2: Learning interpersonal neurobiology

Neurobiology is deeply grounded in basic science. As a result, because of its distance from therapeutic practice, it might be expected that therapists find it hard to assimilate this type of knowledge and apply it in their work with clients. Miller and Barrio Minton (2016) interviewed participants who had completed a 12-day training programme in the use of interpersonal neurobiology for mental health practitioners. In some respects this was an out-of-the-ordinary training programme: all of the participants were experienced therapists, who self-selected to take part (rather than taking the course as a requirement for a degree). The training was facilitated by one of the leading figures in this field, able to draw on a depth of knowledge and experience of using these ideas to inform her work with practice. The training was highly experiential, organised around intensive three-day blocks with many self-exploration activities, a within a small group. These are all optimal conditions for learning.

Two themes emerged very clearly from the interviews. The first is that participants were energised and inspired by what they had learned, and had no difficulty at all in integrating it with their existing skills and theories. The second theme related to *how* these therapists used their new knowledge around interpersonal neurobiology. It was clear that it did not take them in a direction of adopting a detached, 'scientific' stance in relation to their work with clients. Instead, what it seemed to do was deepen their confidence in working in the here-and-now, for example in respect of what was happening in the relationship with the client, and how the client was regulating emotions.

### Risks of uncritical acceptance of a neurobiological perspective

The rationale for integrating a biological, embodied perspective into therapy is that it enables both therapist and client to make use of valuable information that can be helpful in terms of findings ways to deal with problems in living. As with any perspective in therapy, it is important to retain balance. Human beings are psychological, social, and spiritual beings, as well as being embodied. The principle of always working across the bio-psycho-social continuum, an idea that has been highly influential in medicine and healthcare, is equally applicable within counselling, psychotherapy, and related fields.

A balanced approach to assessing the relevance of neuroscience and other aspects of bodily functioning for counselling and psychotherapy might take account of the possibility that these developments are a response to the over-cognitive, 'disembodied', and verbal approaches that dominated therapy practice for many years. Another dimension of balance involves consideration of the fact there is little clear-cut evidence that neuroscience-informed therapy is more effective than any other type of therapy.

Beyond the need to retain balance, there are some specific risks associated with uncritical acceptance of a neurobiological perspective in therapy. One source of risk is concerned with attributing too much importance to particular neurobiological research findings or theories. Although a lot is known about how the brain functions, scientists who specialise in this area acknowledge that there is also a lot that is not known. There can be a tendency for therapists to seize on bits of neurobiological knowledge that confirm their own therapy theories, and ignore other evidence that does not fit their pre-conceived ideas.

Another major risk arises from the authority and certainty that is sometimes attributed to medical and biological knowledge within our society. We live in a world in which it sometimes appears as though all aspects of our lives are disputed – how to bring up our children, what kind of political system is best, and so on. It is therefore reassuring to believe that there are some things that are factually true, because they are based on verifiable biological processes that have been proven through the application of rigorous scientific methods. This belief is reinforced by the observation that medical treatments based on this kind of objective biological knowledge save lives. The perceived credibility and authority of biological perspectives on emotional, relational, and mental health issues raises ethical concerns: it has been suggested that some therapists have overstated the extent to which their approach is based on biological research evidence (Bott et al. 2016).

It is also important to recognise that there is extensive evidence of harmful effects of pharmacological treatments for conditions such as psychosis, anxiety, depression, and ADHD (see, for example, Whitaker and Cosgrove 2015). In this area of applied neurobiology, drug companies and the psychiatric profession worked together to persuade the public that such conditions were due to biochemical imbalances in the brain and could be remedied by taking medication. These claims have been found in many instances to be false. It has now become apparent that long-term use of such medication may produce dependency and possibly even irreversible damage to brain function.

A final negative consequence of neurobiological perspective on mental health and psychotherapy is that this type of research is costly, thereby diverting resources from studies of practical, community-based social and psychological forms of help (Lewis-Fernandez et al. 2016).

## Conclusions

This chapter has approached the field of biologically informed therapy from the position that, while it can offer specific insights, it does not yet (and perhaps never will) afford a comprehensive account of what happens in therapy. Advances in theory and research in neurobiology mean that important discoveries are being reported all of the time. Thus, it has not been possible to offer a comprehensive account of this area of knowledge and practice; the aim, instead, has been to highlight key themes and possibilities.

Neuroscience has made a major contribution to contemporary counselling and psychotherapy by drawing attention to myriad ways in which human functioning and emotional life are based in physical, biological, and embodied processes. This perspective has made it possible for clients and therapists to rediscover the importance of experiences and activities that are crucial aspects of being human. Neurobiological ideas have allowed therapists to understand and make use of ancient traditions of healing, such as meditation and dance, as well as develop many new therapeutic ideas and strategies. In the longer term, one of the most significant implications of this movement may be the gradual dissolving of Western ideas of mind–body dualism that have resulted in the disciplinary separation of physical and psychological types of pain or ailment. For many people, unhappiness and illness are manifested through both physical and psychological dimensions of experience. Advances in neuroscience make it possible to move in the direction of more integrated forms of care.



### Topics for reflection and discussion

- 1 In what ways, and to what extent, are you able to use awareness of your own bodily state to guide you in dealing with difficulties in your life?
- 2 In what ways, and to what extent, do you make use of physical activities, such as movement and exercise, yoga, dance, or being outdoors, to help you to deal with difficulties in your life?

- 3 In what ways, and to what extent, do you make use of mind-altering substances, such as medication, alcohol, street drugs, or food, to help you to deal with difficulties in your life?
- 4 As a therapist, how useful are ideas from neuroscience and neurobiology in relation to your practice? What further learning, study, and training would you ideally like to undertake around these topics?

## Suggested further reading

The work of Daniel Siegel is essential reading for anyone interested in the relevance of neuroscience for psychotherapy – a good starting point is his *Pocket Guide to Interpersonal Neurobiology* (Siegel 2012). An accessible introduction to what it is like to work with clients to enable them to develop body awareness can be found in Erskine (2014). *The Brain-Savvy Therapist's Workbook* (Badenoch 2011) provides a wealth of ideas around how to bridge the gap between neuroscience theory and research, and everyday therapy practice. *The Master and His Emissary: The Divided Brain and the Making of the Western World* (McGilchrist 2012) is one of the all-time classics in the field of neuroscience and neurobiology – a fascinating account of how the structures of the brain shape all aspects of our experience of reality and ways of living.

# Chapter 20

## Integrative therapies

<b>Introduction</b>	<b>282</b>
<b>The underlying similarities across theories of therapy</b>	<b>282</b>
<b>The movement towards integration</b>	<b>283</b>
<b>The debate over the merits of integrated versus ‘pure’ approaches</b>	<b>284</b>
<b>Strategies for achieving integration</b>	<b>285</b>
Technical eclecticism	285
Common factors and the contextual model	287
Theoretical integration: integrated approaches	288
<i>Reality therapy</i>	289
<i>The Egan ‘skilled helper’ model</i>	289
<i>Cognitive analytic therapy</i>	290
<i>The integrated psychotherapy model of Héctor Fernández-Álvarez</i>	291
<i>Reflecting on integrated therapy</i>	291
Theoretical integration: integrative approaches	292
<i>Modular/phased integration</i>	292
<i>Meta-theoretical integration</i>	293
<i>Formulation-driven integration</i>	293
Disorder-based integrative approaches	293
Personal or assimilative integration	293
Principle-driven integration	294
Unified psychotherapy	295
A common language for therapy	295
Collective integration	296
Pluralism	296
‘Adapted’ approaches to therapy	296
<b>Conclusions</b>	<b>297</b>
<b>Topics for reflection and discussion</b>	<b>298</b>
<b>Suggested further reading</b>	<b>298</b>

## Introduction

This chapter addresses the issues involved in combining ideas and methods from different therapy approaches and traditions. Earlier chapters reviewed the most widely used specific ‘brand name’ theories and approaches within contemporary therapy, ranging from the beginnings of psychotherapy in the work of Sigmund Freud to the most recent developments in postmodern practice. Some therapists train in a single theoretical orientation, and stick with that set of ideas and methods throughout their career. By contrast, other practitioners undertake training that exposes them to a range of ideas, or seek ways of combining different concepts and techniques in their work with clients.

Operating from the assumption that there are valuable ‘truths’ in many theories of therapy, more and more counsellors and psychotherapists have begun to develop their own *personal* approach, consistent with their life experience, cultural values, and work setting. However, it can be challenging to combine theoretical ideas: each discrete theoretical orientation comprises a coherent set of principles and methods around how to do therapy. Some of these principles do not readily map on to each other, or may even appear to contradict each other. Similarly, different interventions or therapy techniques may be difficult to combine. On the other hand, the attraction of an integrative approach is that it allows the therapist and client to make use of the widest possible set of ideas and methods.

It is important, in exploring the issues and strategies associated with the practice of integrative therapy, to be aware of different ways in which the term ‘integration’ is used. ‘Integrating’ can be defined as combining or blending elements into some kind of whole. In the field of therapy, the product of this process can sometimes take the form of a model of therapy. Usually, the term *integrated* therapy is used to refer to such a product. Alternatively, the product can be a set of ideas and interventions that are tailored, in a flexible way, to the needs of each particular client. This can be described as *integrative*. As a label for therapy, neither ‘integrated’ or ‘integrative’ makes any reference to the focus or *content* of the therapy (in contrast to, for example, cognitive–behavioural or psychodynamic, each of which describes a specific set of procedures). Instead, the use of the term ‘integration’ refers to an active *process*, on the part of the client and therapist, of building or making something. This implicit meaning can be empowering and encouraging for clients. For example, a client entering cognitive–behavioural therapy might have a nagging doubt around ‘what about my feelings, my relationships, my spirituality – won’t I be allowed to talk about these aspects of my life?’ By contrast, an integrated or integrative approach to therapy offers a more open agenda. The growing popularity and influence of integrated and integrative approaches to therapy is in large part due to the significance, for many clients and therapists, of implicit messages that are subtly conveyed by this way of talking about therapy.

## The underlying similarities across theories of therapy

From the very beginnings of the emergence of counselling and psychotherapy as mainstream human service professions, it has been pointed out that the similarities between theoretical approaches are much greater than their differences. For example, in 1940 the psychologist Goodwin Watson organised a symposium at which well-known figures such as Saul Rosenzweig, Carl Rogers, and Frederick Allen agreed that factors such as support, a good client–therapist relationship, insight, and behaviour change were common features of all successful therapy (Watson 1940). An early piece of research by Fiedler (1950) found that therapists of different orientations held very similar views regarding their conception of an ideal therapeutic relationship.

Perhaps the most influential writer in this area has been Jerome Frank, whose book *Persuasion and Healing* (originally published in 1961; most recent edition 1993) has been a seminal text in the field of psychotherapy. Frank argued that the effectiveness of therapy is not primarily due to

the employment of the specific therapeutic strategies advocated by the various approaches (e.g. free association, interpretation, systematic desensitisation, disowning irrational beliefs, reflection of feeling), but is attributable instead to the operation of a number of general or 'non-specific' factors. Frank (1974) identified the principal non-specific factors as being the creation of a supportive relationship, the provision of a rationale by which the client can make sense of their problems, the instillation of hope, the expression of emotion, and the participation by both client and therapist in healing rituals. The model of non-specific therapeutic factors created by Jerome Frank is all the more convincing in that his analysis was based not only on the study of psychological therapies in Western industrial societies, but also incorporated evidence from investigations of healing practices in all cultures.

The 'non-specific' hypothesis has stimulated extensive debate within the field (Hill 1989; Parloff 1986; Strupp 1986), since it directly challenges the beliefs of most counsellors and therapists that it was their hard-learned specific techniques and intervention strategies that made the difference to their clients. One of the outcomes of this scholarly activity has been the generation of a large number of suggestions regarding a whole range of non-specific factors not mentioned by Frank (1974). For example, Grencavage and Norcross (1990) compiled a list of all the factors mentioned in a set of more than 50 articles and books on this topic that they had reviewed. They identified four broad categories of non-specific factors: client characteristics, therapist qualities, change processes, and treatment methods. The common factors that were mentioned most often were: the therapeutic alliance, the opportunity for catharsis and emotional relief, acquisition and practising of new behaviours, the client having positive expectations, the qualities of the therapist being a source of positive influence on the client, and the provision of a rationale for the client's difficulties.

There are several sources of evidence that lend support to the non-specific or common factors perspective. Research findings demonstrate that different theoretical orientations, using different specific strategies, report similar success rates. Non-professional counsellors, who have not received enough training to be able to claim mastery of specific techniques, appear to be as effective as highly trained professional therapists. Finally, participants in studies of the experiences of clients in therapy, when clients are asked what they find most helpful, tend to rate non-specific elements more highly than specific techniques.

In conclusion, research into the existence of non-specific or common therapeutic factors has pointed to a vast area of common ground shared by the different therapies (Hubble et al. 1999). Indeed, one of the unintended and unexpected consequences of the expansion of research into the processes and outcomes of specific approaches to therapy, has been the discovery of an ever-expanding list of points of similarity between different approaches.

However, it is not warranted to argue that effective therapy consists *only* of these common factors. There are all sorts of complex interactions between common factors, specific techniques, and theoretical models. For example, the instigation of a specific CBT technique, such as exposure to a feared event, may have the effect of enhancing the potency of common or non-specific factors such as hope ('this is going to help me get better') and the therapy relationship ('my therapist understands and appreciates what I need, and cares enough to organise this intervention that is designed around my needs'). Nevertheless, it makes sense to acknowledge that, at the heart of any therapeutic relationship, there exists a set of generic, common processes.

## The movement towards integration

Historically, the counselling and psychotherapy profession has been largely structured around distinct, separate sets of ideas or theoretical models, such as CBT or psychodynamic, each backed up by its own training institutes, professional associations, and research evidence base. However, despite the institutional and organisational power of distinct schools of therapy, there is considerable evidence that many therapists define themselves as following an integrative approach.



A series of surveys, starting in the 1960s and 1970s and covering a 50-year period, revealed that around half of all therapists described themselves as 'eclectic' or 'integrationist', rather than being followers of any one single model (British Association for Counselling and Psychotherapy 2001a; Garfield and Kurtz 1974; Hollanders and McLeod 1999; Norcross et al. 2005; O'Sullivan and Dryden 1990; Prochaska and Norcross 1983). Studies that have asked therapists to identify the interventions they use most with clients provide further evidence regarding the convergence of therapy practice. Typically, these studies report that most therapists tend to make use of a similar set of interventions, regardless of their espoused theoretical orientation (Solomonov et al. 2016; Thoma and Cecero 2009).

One of the issues thrown up by these studies is the difficulty of finding meaningful ways of collecting information about therapists' theoretical orientations – there are so many different, often highly idiosyncratic, combinations of approaches that it is hard to design a questionnaire that will do justice to what counsellors want to say about themselves (Poznanski and McLennan 1995; Rihacek and Roubal 2017). It is therefore hard to determine, with any confidence, the proportions of therapists who espouse particular approaches, or to interpret historical trends that might be taking place. Findings are also highly dependent on the sample of therapists surveyed, with distinctive profiles of therapeutic orientation reported by practitioners affiliated to different professional organisations. Nevertheless, the trend across all surveys of counsellors and psychotherapists has been that some form of eclecticism/integrationism has either emerged as the single most popular approach, or has been a significant source of influence even among those therapists who describe themselves as based primarily within a single model.

It appears that the profession is gradually moving away from theoretical purity, and in the direction of eclecticism/integrationism. For example, in studies by Norcross et al. (2005) and Rønnestad and Skovholt (2013), respondents were asked to indicate the trajectory of their theoretical development. These authors found that half of the eclectic or integrationist therapists in their sample had previously trained in and defined themselves as committed to a single model, and had gradually added other methods and viewpoints into their original approach in response to the challenges and demands of clinical practice. In addition, 80 per cent of internship and training directors in universities in the USA believe a single model is an insufficient basis for treating a variety of client issues (Lampropoulos and Dixon 2007), and many leading figures (Castonguay et al. 2015; Fernández-Álvarez et al. 2016; Norcross et al. 2013) have argued that integrative approaches are likely to become increasingly influential.

## **The debate over the merits of integrated versus 'pure' approaches**

It is important to recognise that some therapists are strongly opposed to integrative approaches to working with clients. Influential figures such as Eysenck (1970) and Szasz (1974) were resolutely convinced that any form of theoretical combination would inevitably result in muddle and confusion, and that it was necessary to stick to one consistent approach. Theoretical purists argue that there are conflicting philosophical assumptions underlying different approaches, and that any attempt to combine them is likely to lead to confusion or inauthenticity. For example, within psychoanalysis the actions of a person are regarded as ultimately determined by unconscious motives arising from repressed childhood experiences. By contrast, humanistic theories view people as capable of choice and free will. It could be argued that these are irreconcilably opposing ways of making sense of human nature, and can only breed contradiction if combined.

Another type of confusion can be created by taking ideas or techniques out of context. For example, systematic desensitisation is a therapeutic technique that has been developed within a behavioural perspective in which anxiety is understood in terms of a conditioned fear response to a stimulus. A humanistic counsellor who understood anxiety in terms of threat to the self-concept

might invite the client to engage in a process that could superficially resemble systematic desensitisation, but the meaning of the procedure would be radically different. A final source of confusion that can result from an integrative approach reflects the difficulties involved in mastering concepts and methods from different theories. It is hard enough, according to this line of argument, to be a competent counsellor or psychotherapist within one approach, without attempting to achieve a depth of understanding and experience in several contrasting models.

Despite the cogency and trenchancy of the critique of eclecticism and integration mounted by Eysenck and Szasz, it is perhaps worth noting that they were writing in the 1970s. There are few, if any, contemporary figures who explicitly reject the viability of integrationist therapies. Many would agree that, while integration is in principle a desirable aim, it can be difficult to achieve in practice, and that until the issues outlined here have been resolved, it may be safer to stick to unitary approaches.

## Strategies for achieving integration

How can different theories and techniques be combined? Within the counselling and psychotherapy professions, the urge to create a broader, more all-encompassing approach has taken a variety of forms. The main strategies and frameworks that have been developed are discussed in the following sections. By contrast, advocates of therapy integration argue that the fragmentation of the therapy profession into distinct 'schools' is impeding progress at both scientific and practical levels.

### Technical eclecticism

An eclectic approach to therapy is one in which the therapist chooses the best or most appropriate techniques from a range of theories or models, in order to meet the needs of each individual client. One of the distinctive features of eclecticism, as applied in therapy, is that it has focused almost entirely on the selection of therapeutic techniques or procedures, and has paid little attention to the question of the theoretical framework within which these interventions have been developed. The rationale for this position is that, in the end, therapy is delivered in the form of techniques and interventions (Lazarus 1967; London 1964). Eclecticism is a highly pragmatic approach to therapy, which concentrates on 'what works' in practice rather than bothering to any great extent about the underlying images of the person or systems of theoretical constructs.

The term 'eclectic', as a description of a form of therapy practice, was fashionable in the 1960s, but subsequently has dropped out of favour. Although eclecticism is an attractive idea that makes a lot of intuitive sense, the weakness of a purely eclectic approach is that it does not define the criteria on which the choice of technique is to be based. The lack of interest in theory compounds this difficulty, because it eliminates a possible source of criteria that might inform the identification of suitable techniques. In the absence of such criteria, there can be a tendency for the practitioner to select interventions on weak grounds (e.g. 'I attended a weekend workshop on CBT, so all of my clients in the following week will be getting homework assignments'). In recent times, therefore, undefined or 'simple' eclecticism has been regarded by critics as comprising a muddle-headed approach in which the therapist experiments with different techniques in an indiscriminate or undisciplined manner (Norcross 2005).

Practitioners who remain convinced of the potential value of eclecticism have been stimulated by these criticisms to develop a more systematic approach to the selection of techniques. This more rigorous version of eclecticism is called *technical eclecticism*. The practice of technical eclecticism is based on two key principles: (1) careful assessment of the presenting problems, personality, and therapeutic goals of the client; and (2) recourse to research evidence to guide the selection of an effective intervention package, tailored to the characteristics of the client.

There have been two key figures in the development of technical eclecticism, both highly influential clinical psychologists in the USA: Arnold Lazarus and Larry Beutler. The approach constructed

by Lazarus is called multimodal therapy (Lazarus 1989a, 1989b, 2005; see also Eskapa 1992). Clients' presenting problems are assessed within seven discrete domains: behaviour, affect, sensation, imagery, cognition, interpersonal relationships, drugs/biology. Lazarus (1989a, 1989b) uses the term BASIC-ID as a mnemonic for these domains. The task of the therapist is to identify the main focus for client work, using an assessment interview and a multimodal life-history questionnaire, and then choose the most relevant intervention techniques, based on research findings. In practice, the technical eclecticism of Lazarus operates mainly within the cognitive-behavioural realm. A somewhat similar approach has been developed, within a humanistic/creative arts tradition, by the Israeli psychologist Mooli Lahad, with his BASIC Ph framework (belief, affect, social, imagination, cognitive, physiological) (Lahad 1992, 1995, 2002). The BASIC Ph system, which has been widely used in work with children, is less rigorously grounded in research evidence than is the multimodal therapy model.

Although there is still a thriving international network of practitioners who use the Lazarus model of multimodal therapy, it is important to note that in recent years the term 'multimodal' has been increasingly applied to situations, not influenced by the work of Lazarus, in which therapy consists of different modes of delivery of treatment (see, for example, Dinger et al. 2017; Randal et al. 2003). For example, in the study by Dinger et al. (2017), clients engaged in a wide range of therapeutic activities, including individual psychodynamic psychotherapy, psychoanalytic group therapy, art therapy, music therapy, movement therapy, social skills training, and family work.

The other significant contribution to technical eclecticism is the *systematic treatment selection* approach developed by Beutler and his colleagues (Beutler 1983; Beutler and Clarkin 1990; Beutler et al. 2005). The assessment matrix used in systematic treatment selection is organised around six key variables: problem complexity, chronicity, level of functional impairment, coping style, resistance level, and distress. An attractive feature of this approach, for many practitioners, is the extent to which it is highly sensitive to the personality and moment-by-moment experiencing of the client. For example, clients whose personality structure is built around externalising their problems will respond better to interventions that provide a high degree of structure, whereas those who tend to internalise their problems will respond better to interventions that promote insight and self-awareness. Similarly, the client's immediate level of distress functions as an indicator of whether the therapist should provide support or challenge. The approach goes beyond the original emphasis in technical eclecticism, on technique, and opens up a range of possibilities around shaping the client-therapist *relationship* in accordance with the client's needs. It is perhaps worth noting that the original training received by Larry Beutler was in client-centred therapy (see Beutler 2001).

A major advantage of technical eclecticism is that this perspective on integration is largely atheoretical and thus avoids pointless debate over the compatibility (or otherwise) of theoretical constructs. On the other hand, by focusing largely on technique rather than theory, there is a danger that this approach misses out on some, or all, of the valuable functions of theory in relation to supplying organising principles for practice. A key challenge for technical eclecticism is that, properly applied, it relies on the existence of sound research evidence concerning the effectiveness of particular techniques with particular categories of client. Such evidence is frequently not available, forcing the clinician to rely on their personal experience, which will have been at least partly shaped by theoretical assumptions, suppositions and other factors. A further challenge lies in the fact that technical eclecticism calls for a high level of knowledge and competence on the part of the practitioner, in respect of assessment procedures, familiarity with the research evidence, and the effective delivery of specific techniques.

Eclecticism has a great deal to offer as a strategy for combining ideas and methods from different therapy traditions (Lazarus et al. 1992). The 'bad press' that eclecticism has received may be attributable to its status as the earliest form of therapy integration to receive widespread publicity – to a large extent, other approaches to integration (discussed next) have based their credibility on defining the ways in which they are 'better than' eclecticism. The abiding appeal of eclecticism, for counselling and psychotherapy practitioners, can be seen in the wide sales of books that provide catalogues of techniques, such as those by Carrell (2001), Seiser and Wastell (2002), and Yalom (2002).

### Box 20.1: The limitations of therapy based on a single approach

The research literature on the effectiveness of therapy includes a large number of studies that demonstrate the effectiveness of ‘pure’, single-theory approaches (see Lambert 2004). However, there is also evidence that at least some clients are unhappy with what they experience as rigidly defined therapeutic regimes. In one study, based on in-depth interviews with clients who had received psychodynamic psychotherapy, Lilliengren and Werbart (2005) found that around 40 per cent of the clients felt that there had been ‘something missing’ in their therapy. Although most of these clients reported that they had benefited from what their therapist had been able to offer, they also believed that there had been an intrinsic limitation in what was provided, with the effect that their therapy was experienced as incomplete.

A collection of articles written by strongly dissatisfied clients, and edited by Bates (2006), provides a different kind of evidence. The recurring theme, in the stories of these clients who felt that they had been damaged by their therapy, was not necessarily that their therapist was exploitative or personality disordered, but that they were ideologically far too rigid – when a particular approach or line of intervention was clearly not working, they persisted in increasing the intensity of the intervention, rather than trying something different.

### Common factors and the contextual model

The common factors approach to therapy integration is associated with the work of Scott Miller, Barry Duncan, and Mark Hubble, and more recently Bruce Wampold. The guiding principle in this form of integration is the writings of Jerome Frank (1974), which identified a number of therapeutic elements (or ‘common factors’) that were present in all forms of counselling and psychotherapy, and indeed in healing practices worldwide. Miller, Duncan, and Hubble (S. D. Miller et al. 1997, 2005; Duncan and Miller 2000; Hubble et al. 1999) regard four common factors as particularly important: extra-therapeutic events (helpful experiences that occur outside of the therapy room – for example, the client becoming friends with someone who is supportive to them); the therapy relationship; the instillation of hope and positive expectations for change; and specific ‘therapy rituals’ (the structure of the therapeutic work, the use of techniques). They argue that within our culture there are many competing and alternative theories about what causes personal problems, and how such problems can be resolved, and that it is therefore necessary to base therapy on the ‘theory of change’ espoused by each individual client: interventions should be complementary to the *client’s* theory.

The secret of effective therapy, from a common factors perspective, is to pay attention to ‘what works’ for each client, by using the client’s beliefs as a starting point, and subsequently obtaining regular feedback regarding the client’s experience of the process and outcome of therapy. Feedback is collected during sessions (‘what would be helpful now?’, ‘how helpful was that discussion we just had?’) and across sessions. At the start of each session, the Session Rating Scale (SRS) is used to evaluate the quality of the therapeutic relationship, and the Outcome Rating Scale (ORS) is used to monitor the amount of change achieved by the client. These are brief scales, which take only a few minutes to complete. The aim is to give the client an explicit opportunity to communicate their views about what is working, and not working, in the therapy. Evidence that the therapy is working is an indication to continue as before. Evidence that it is not working is a signal to pause and review what has been happening, and in particular to reflect on whether the four common therapeutic factors are being implemented to a sufficient degree.

Although the core members of the common factors group have been primarily influenced by ideas from solution-focused therapy (Miller et al. 1996), their approach can be readily adopted by

any counsellor or psychotherapist, whatever their primary theoretical orientation may have been. From a common factors point of view, almost anything can be therapeutic – the essential criterion is whether it makes a positive difference to the client. The common factors group position themselves as radical critics of mainstream therapy; they describe what they do as a ‘new way to think about therapy’ (Miller 2004), and maintain a website (<http://scottdmiller.com/>) that seeks to interpret a range of professional issues from a common factors perspective in which the client is portrayed as a heroic figure who is resourcefully seeking to improve their life (Duncan et al. 2004).

Recently, further elaboration of the common factors perspective has taken the form of the *contextual model* of therapy (Wampold and Imel 2015), which argues that, in practice, there exist a set of key common factor clusters, oriented around building a real relationship, negotiating expectations, creating a plausible explanation and treatment plan, the therapist’s personal commitment and belief in what they have to offer, and the therapist’s commitment to learning. These domains, taken together, provide a context within which specific treatment interventions can be effectively applied.

The common factors approach to therapy integration has been highly influential, in terms of providing a coherent counter-argument to the proponents of theoretical purity. The idea of common factors has served to liberate many practitioners from the intellectual confines of their initial, single-theory training. However, until now, the common factors model has not stimulated the formation of a professional community beyond the Miller, Duncan, and Hubble group. This may be because the common factors model does not actually specify what a therapist should do, in terms of specific procedures and techniques (other than access the client’s theory of change, and use outcome information). The common factors model operates as a kind of ‘meta-perspective’, which is useful for therapists who are already competent in a range of specific methods.

### Box 20.2: Hope as a common factor

The instillation of hope was identified by Jerome Frank (1974) as a common factor in all forms of emotional healing. Since that time, there has been a substantial amount of research into the ways in which counselling and psychotherapy can help clients to develop hope that their problems can be overcome. For example, Larsen and Stege (2012) interviewed clients about what their counsellors did in early sessions that led to them feeling more hopeful. What they found was that ordinary counselling responses, such as inviting the client to talk about themselves, could have a positive hope-inducing impact. This kind of finding, that what seems to happen in effective therapy is that a general hopeful stance on the part of the therapist is subtly conveyed to the client in a myriad of different ways, is backed up by results from several other studies. A comprehensive overview of theory and research on the role of hope in counselling and psychotherapy can be found in O’Hara (2013).

### Theoretical integration: integrated approaches

Theoretical integration can be defined as the construction of a new approach to therapy that brings together concepts and methods from already existing approaches. A key strategy in achieving theoretical integration is to find a central theoretical concept or framework within which existing ideas can be subsumed. Barkham (1992) suggested that successful implementation of this strategy involves the identification of higher-order constructs that can account for change mechanisms beyond the level of any single model. The aim is to produce a cognitive ‘map’ that will enable the links and connections between ideas and techniques to be understood. There are several examples of approaches to counselling and psychotherapy that have effectively employed higher-order or transtheoretical constructs in this way, to create a new theoretical integration: reality therapy,



the Egan 'skilled helper' model, the self-confirmation model, cognitive analytic therapy, and the integrated psychotherapy model.

### *Reality therapy*

Reality therapy represents one of the most theoretically interesting approaches to counselling and psychotherapy that can be found within the current literature, because it brings together ideas from several therapy traditions. Reality therapy was founded by William Glasser, a psychiatrist, in 1965, and has been widely adopted in many countries around the world, including Malaysia and Taiwan. It has been extensively used by schools counsellors. Pryzwansky et al. (1984) reported that it was the most widely applied specific model in a survey of schools counsellors in the USA carried out in 1981. It has also been used in marital/couple counselling, and therapy for survivors of sexual abuse (Ellsworth 2007), as well as in general counselling practice. The use of reality therapy in counselling is supported by accredited training programmes, a journal, and a programme of research (Wubbolding 2000).

The central or 'transtheoretical' construct that lies at the heart of reality therapy is the concept of *choice*. Glasser (2000: xv) contends that 'we choose essentially everything we do'. The main focus of therapy is therefore to encourage the client to stop choosing to do things that lead to unhappiness, and to begin to choose to do things that are consistent with their inner sense of what is right for them (their internal 'quality world'). The emphasis on choice, alongside a lack of interest in exploring how the client feels, might appear to locate reality therapy as a member of the cognitive therapy/CBT family of therapies. Reality therapy incorporates strategies for cognitive change that could, in fact, be seen as an improvement on standard CBT practice. For example, reality therapists do not require clients to spend time identifying irrational thoughts or negative automatic thoughts, as a precursor to changing these cognitive patterns. Rather, reality therapists get straight to the point of all this, which is to choose to see the world in a different way. In addition, reality therapy pays special attention to the language that the client uses to talk about their problems, and teaches clients to use 'choice language' – for example, rather than 'being depressed', a person 'depresses' themselves. This new way of talking has the effect of taking the client a step closer to choosing not to 'depress' themselves.

However, there are other elements of reality therapy theory and practice that are significantly different from cognitive therapy or CBT. The main difference lies in the emphasis in reality therapy on the importance of relationships. Reality therapy is a profoundly relational therapy, in that there is a general assumption that the reason why clients seek counselling is that they experience a specific relationship difficulty. Reality therapy includes a model of human needs, and how satisfying relationships depend on each partner's needs being satisfied. There is also a strong value position based on the principle that people should not try to control others. Overall, therefore, reality therapy consists of a creative synthesis of ideas and practices from both cognitively oriented and relationship-oriented approaches to therapy. Some reality therapy themes also reflect aspects of existential therapy, for instance around the importance of personal responsibility.

For reasons of space, this summary of reality therapy theory and practice inevitably reflects only a partial and incomplete account of what it has to offer. Further information is available from two contrasting sources. Glasser (2000) provides a highly accessible introduction to reality therapy, based on numerous case examples. By contrast, Wubbolding (2000) provides a more formal, structured introduction. Reality therapy represents a prime example of theoretical integration based on the bold and rigorous use of a central construct (choice) as an organising principle for therapy practice.

### *The Egan 'skilled helper' model*

An example of a theoretical approach to integration that is widely used within the world of counselling is the 'skilled helper' model constructed by Egan (2009). The key integrating concept chosen by Egan is that of *problem management*. Egan suggests that clients who seek assistance from



counsellors and other helpers are experiencing difficulties in coping with problems in their lives, and that the primary task of the helper is to enable the person to find and act on appropriate solutions to these problems. The emphasis is therefore on a problem-solving process, involving three stages. First, the client is helped to describe and explore the 'present scenario', the problem situation that they are faced with at the present time. The second stage is to articulate a 'preferred scenario', including future goals and objectives. The third stage is to develop and implement action strategies for moving from the current to the preferred scenario.

Egan describes substages within each of the three stages, and identifies the client tasks and helper skills necessary to facilitate this problem-solving process. The Egan model can usefully be viewed as a 'map' through which the usefulness of relevant elements of other approaches can be located and evaluated. For example, the concept of empathy is taken from client-centred theory and regarded as a communication skill essential to the helping process, and the idea of congruence is included under 'immediacy'. From a psychodynamic perspective, the aim of insight is included in Egan's goal of identifying and challenging 'blind spots' in the client.

Many counsellors and therapists have used the Egan model as a framework through which they can employ techniques and methods from a wide range of approaches – for example, gestalt exercises as a way of challenging blind spots or assertiveness training as a way of developing action strategies. A case study in Inskipp and Johns (1984) illustrates some of the ways in which various ideas can be included within the skilled helper model. Wosket (2006) reviewed recent developments and applications of the Egan model in a range of settings.

The main strengths of the skilled helper model are that it offers an intensely practical and pragmatic approach to working with people, and that it is applicable to a wide variety of situations, ranging from individual counselling to organisational consultation. As an integrated approach, its limitation is that it is primarily based on a cognitive-behavioural perspective. Although the model clearly encompasses some elements of humanistic and person-centred thinking, through such concepts as respect, immediacy, and empathy, it includes very little from the psychodynamic approaches.

### *Cognitive analytic therapy*

Cognitive analytic therapy (CAT) is an integrationist approach that is widely used in Britain. It was originally developed by Anthony Ryle (1990) and has been further articulated through a number of publications (Ryle 1995, 2005; Ryle and Cowmeadow 1992; Ryle and Kerr 2002). The key theoretical concept that underpins CAT is the idea of the *procedure*: a sequence of goal-directed behaviour that incorporates cognitive, emotional, and social processes. Cognitive analytic therapy is based on ideas from cognitive psychology and cognitive therapy, psychoanalysis, and developmental psychology. The cognitive dimension of the model concerns the ways that people engage in intentional activity through sequences of mental and behavioural acts. In pursuing their life goals, people run into trouble when they encounter traps, dilemmas, and snags. The psychoanalytic dimension of this model includes the Freudian idea of defence mechanisms as examples of cognitive 'editing', and takes account of the origins of traps, dilemmas, and snags in early parent-child interactions.

In practice, CAT is implemented through brief therapy (16 sessions), which begins with an exploration of the life history and current functioning of the client. This leads on to a reformulation of the difficulties being experienced by the client, in which the counsellor or therapist identifies targets for change, using diagrams, and letters from the therapist to the client to define the key ideas in a form that is visible and memorable. One of the significant features of CAT is the extent to which it has remained open to further sources of theoretical influence. For example, in recent years CAT theorists have integrated ideas concerning the dialogical nature of human communication (Hermans and DiMaggio 2004; Leiman 1997). Cognitive analytic therapy has also been adapted for work with different client groups, such as offenders, people with health problems, older people, and individuals with learning difficulties. A useful brief introduction to the approach can be found in Corbridge and Brummer (2017).

### *The integrated psychotherapy model of Héctor Fernández-Álvarez*

The integrated psychotherapy model probably represents the most widely used and conceptually ambitious integrated approach that is currently available. Initially developed in the early 1990s (Fernández-Álvarez 2001), it has been supported and evaluated through the work of the Aiglé Foundation in Argentina, including the establishment of training programmes and research (see, for example, Fernández-Álvarez et al. 2003). A valuable brief introduction to this approach can be found in Fernández-Álvarez et al. (2016). The key integrating principle is a broad bio-psycho-social perspective, comprising different levels of cognitive processing and meaning-making that correspond to different developmental stages. This framework makes it possible to accommodate concepts from all of the major theories of therapy. A distinctive aspect of the model is the wide range of strategies that are available to therapists when working at different levels with clients. A detailed case example of how the approach works in practice, with an extremely troubled client, is available in Scherb (2014).

### *Reflecting on integrated therapy*

The fundamental difficulties of theoretical integration, as well as its potential, can be examined through reflection on the approaches outlined above. Although all five models successfully integrate previously existing sets of ideas, they all arrive at a different result regarding a suitable overarching concept or principle. A notable feature of these integrated approaches is that they bring together some ideas but clearly reject others; they are *partial* integrations of previous theory. In effect, Glasser, Egan, Andrews, Ryle, and Fernández-Álvarez have each arrived at new theories of therapy. Other integrated therapy models can be found in Corey (2010), Erskine and Moursund (2011), Gilbert and Orlans (2010), Holmes and Bateman (2002), Lapworth et al. (2001), O'Brien and Houston (2007), and elsewhere. Although all of these approaches are valuable, and have their adherents, it could be argued that, by adding to the already long list of different therapies, they have inevitably fragmented the counselling and psychotherapy world even further. On the other hand, each of these integrated approaches supplies a complete and detailed specification of how to do therapy. This means that people can be trained, from scratch, to deliver these interventions, and that research can be carried out into their effectiveness (see Schottenbauer et al. 2005; Zarbo et al. 2016). For practitioners and trainees, integrated models of therapy provide a relatively straightforward route towards broadening the theoretical base of their practice, through learning more about, and receiving training in, a broad-based way of working that has already been formulated by others. Trying to achieve full-scale theoretical integration on the basis of individual study and experimentation represents a hard road to follow.



### **Case study 20.1: Symptom-oriented versus person-oriented approaches to therapy – a false dichotomy?**

Within the counselling and psychotherapy professional community, a strong source of resistance to forms of integration comes from practitioners who adhere to the idea that effective therapy, and in particular successful brief therapy, needs to stick to a single aim or focus. Omer (1993) divides therapists into those who believe in the value of a symptom-oriented focus, for example cognitive-behavioural therapists who work with clients to identify cognitive or behavioural goals, and those who adopt a person-oriented focus, for example psychodynamic and person-centred practitioners who work with clients around relationship patterns. Omer (1993) argues that, in contrast to these polarised approaches, an integrative focus does not assume that there is any one basic level (i.e. symptomatic or relational) to which all problems can be reduced, but that problems can always be understood from a variety of perspectives. He points out that, from the client's point of view, the problems with which they are struggling nearly always have a symptom dimension and a person dimension.

Omer (1993) describes the case of Sara, a 44-year-old woman who presented with symptoms of claustrophobia and agoraphobia, and could not enter elevators or aircraft, or drive in open areas. As Sara began to explore these problems, it emerged that she had grown up in a family in which there were constant worries about the dangers and catastrophes that lurked in the external world. She also described difficulties in her marriage – her husband indulged in extramarital affairs, and was highly critical of her fear of flying. In acknowledgement of both the symptomatic and personal-relational aspects of Sara's concerns, Omer (1993) offered her a formulation based on the tension between Sara's wish for independence (both from her parents and husband) and her fear of losing a secure lifestyle. From this perspective, progress in dealing with her phobias would lead to personal expansion and autonomy, while enhancing personal expansion and autonomy would make her stronger to fight her phobias. This integrative formulation had a catalytic effect in mobilising Sara's energies, and setting her on a path that would eventually result in a more satisfying life. Omer (1993) points out that formulations that link together symptoms and broader personal-relational themes make a lot of sense to clients, and typically remain in their minds and operate as a guide for action. He suggests that they also have the effect of liberating the therapist from the unnecessary constraint of refusing to give full attention to an issue (whatever side of the symptom versus person polarity that is being ignored) that is of great significance to the client. An *integrative* focus therefore serves to enhance the quality of the client–therapist alliance.

## Theoretical integration: integrative approaches

In contrast to formal integrated approaches to therapy that have emerged from lengthy theoretical analysis on the part of leading figures in the world of therapy, there are also a set of strategies for flexible theoretical integration in response to the needs of specific clients. The following sections offer brief introductions to three such strategies: modular/phased integration, meta-theoretical integration, and formulation-driven integration.

### *Modular/phased integration*

Modular or phased integration represents a strategy for going beyond single therapy approaches, and allowing clients to benefit from a wider range of change processes, while continuing to take advantage of the coherence of these root models. The strategy involves offering the client a block of sessions based on one approach, followed by a block that makes use of a contrasting theory. An example of this kind of integration can be found in a case study published by Pass (2012), which describes therapy offered to a female client who had experienced severe trauma following a single event – directly witnessing the suicide of her brother. Therapy consisted of three phases. First, a psychodynamic approach was used to help the client to explore and become aware of her feelings and attachment/relationship issues associated with the traumatic event. Therapy then moved to a phase in which expressive writing tasks were used to facilitate re-processing of the trauma. The final, third stage of therapy involved reflection and consolidation. A case that was reported by Ritter and Moore (2012) provides an account of therapy with a client whose depression was associated with feelings of worthlessness, failure, and guilt arising from living with a critical, domineering, and controlling mother. In the light of these issues, it seemed appropriate to adopt a psychodynamic approach. However, the client did not improve after three months of therapy, and it was decided that the work might then switch to a CBT model, which turned out to be effective. These cases reflect situations where discrete blocks or phases of specific therapy were implemented on the basis of therapist clinical judgement. A more systematic strategy for phased or modular therapy makes use of research evidence and assessment of client personality factors, at the start of therapy, to design a 'personalised' sequence or package tailored to each client (see, for example, DeRubeis et al. 2014; Solomonov and Barber 2016). At the present time, the research evidence is not sufficiently precise to enable this kind of research-driven strategy to be pursued in a reliable manner.

### *Meta-theoretical integration*

The idea that effectively combining theories of therapy requires the adoption of an overarching meta-theory or meta-perspective has already been discussed in relation to formal integrated therapy models such as choice theory and cognitive analytic therapy. This strategy can also be used by individual practitioners in a more open-ended way. For example, some therapists use a broadly feminist, multicultural, and social justice meta-theoretical perspective to guide their work with clients. Case studies that explore in detail how this works in practice have been published by Carr and West (2013) and Richmond et al. (2013).

### *Formulation-driven integration*

Integrative case formulation represents a valuable procedure that can be used to bring together contrasting theoretical perspectives that have the potential to be helpful in work with a specific client (Ridley and Jeffrey 2017). The process of developing a case formulation that draws on two or more theoretical perspectives requires the therapist to give careful consideration to the relevance of various concepts and interventions in relation to the problems presented by the client, and also make it possible to reflect on any potential areas of conflict across the models. Discussing the formulation with the client then allows them to provide input, such as whether aspects of each approach are helpful or unhelpful in their view. An example of how this strategy can be used has been described in a case study (Drury and Alim 2012). The male client, who was experiencing both anger/relationship issues and loss/bereavement, received a therapy experience that was closely tailored to his needs and preferences, using the case formulation as an anchor for the work.

## **Disorder-based integrative approaches**

A variant of theoretical integration can be found in therapy protocols that have been developed to respond to the needs of specific client groups. The most influential example of this integrative strategy can be found in dialectical behaviour therapy (Heard and Linehan 2005; Linehan 1993a, 1993b). Dialectical behaviour therapy was a response to the widely recognised difficulties in conducting effective therapy with people who were diagnosed as having ‘borderline personality disorder’. These are individuals who tend to have major problems in sustaining relationships, due to highly self-destructive patterns of behaviour up to and including suicide attempts. The founder of DBT, Marsha Linehan, identified that clients in this category had been brought up in ‘invalidating’ family environments, in which they were harshly criticised, and had learned to suppress their awareness of their emotions. She realised that in addition to core CBT interventions around behaviour change, emotional self-regulation, and social skills, such clients required a strongly affirming relationship with a therapist. Dialectical behaviour therapy therefore comprises an integration of ideas from both CBT and relationship-oriented therapy approaches such as person-centred and psychodynamic.

Another example of a disorder-based integrative model is the Understanding Your Eating programme developed by Julia Buckroyd, aimed at people who engage in emotional eating. This approach makes use of family systems theory, and psychodynamic concepts such as attachment theory, as a means of helping participants to gain an understanding of the origins and interpersonal function of binge eating, alongside cognitive-behavioural strategies to provide support with eating patterns (Buckroyd 2011; Buckroyd and Rother 2007).

Further examples of integrative approaches constructed for specific client groups can be found in Norcross and Goldfried (2019).

## **Personal or assimilative integration**

An especially fertile approach to understanding integrationism is to view it as a personal process undertaken by individual counsellors and psychotherapists, arising from ongoing personal and professional development over the course of their careers. Several writers have commented that one of the central tasks for any therapist is to develop their own personal approach (Lomas 1981;

Smail 1978). Some therapists have shared the highly differentiated personal conceptual maps that they have constructed to guide their work with clients (see, for example, Hansen et al. 2015; Shahar 2013). It is interesting that even though they have not formed the basis for schools of therapy, these 'personal' models of therapy are just as sophisticated and research informed as any well-known published theories.

The process of integration at an individual level has been described as assimilative integration (Messer 1992). *Assimilative integration* can be defined as a 'mode of integration [that] favors a firm grounding in any one system of psychotherapy, but with a willingness to incorporate or assimilate, in a considered fashion, perspectives or practices from other schools' (Messer 1992: 151). The key principle in this form of integration is that the therapist begins their career by being trained in a 'pure' single-theory approach (e.g. psychodynamic, person-centred, cognitive-behavioural). As the practitioner gains experience and confidence, they read outside of their primary approach, and may attend training workshops and courses on other models and new techniques. Each of these new ideas is interpreted in the light of the primary model, and is either rejected or is found a place (i.e. assimilated) in the practitioner's initial theoretical structure of understanding and intervention.

The driving force for assimilative integration is a sense that an existing approach can be enhanced or extended by the inclusion of new elements, as long as these new elements do not undermine the balance of the practitioner's previous network of ideas and methods. It is worth noting that, unlike technical eclecticism, assimilative integration embraces the incorporation of new concepts as well as new techniques.

Some of the best examples of assimilative integration in action can be found in the writings of the psychodynamic psychotherapists George Stricker and Jerry Gold (Stricker 2006; Stricker and Gold 2005). Assimilative integration is a process that unfolds over the working life of any therapist who is interested in expanding their repertoire. Messer (1992) suggests that there is a point where assimilation (into a pre-existing theory) becomes *adaptation* (the underlying theoretical structure is fundamentally changed into something new). It may be, therefore, that the bend-point of assimilative integration, at least for some therapists, is a point of arrival at their own personal theoretical assimilation (i.e. construction of a distinctive new model).

The model of assimilative integration described by Messer (1992) represents, for many practitioners, an attractive and relevant pathway towards integration. It is a strategy that allows a therapist to remain grounded in a primary approach while gradually trying out different ideas and techniques, and provides a secure set of criteria for evaluating these innovations ('are they consistent with what I already know?'). A valuable source of understanding, in relation to the diversity of pathways that assimilative integration can follow, can be found in a growing research literature on this topic, based on interviews with therapists (Rihacek and Danelova 2015; Rihacek et al. 2012), therapist autobiographical accounts (Marzillier 2010; Norcross 2006b; Rihacek and Danelova 2016), and case reports (Cohen 2016; Robbins et al. 2008).

## Principle-driven integration

Increasingly, unitary single-theory approaches are defined in terms of treatment manuals and protocols that specify detailed procedures or rules that should be followed. Although this strategy is valuable for training and research purposes, it has the inevitable effect of highlighting the distinct features of approaches and the differences between them. It can also lead to a 'tick-box', mechanistic way of working, which inhibits therapist responsiveness and creativity. Levitt et al. (2005) have argued that it is more appropriate to understand therapy practice in terms of principles rather than rules, and have carried out a number of studies in which therapy principles have been identified from the perspective of both clients (Levitt et al. 2006) and therapists (Levitt and Williams 2010). An example of a therapeutic principle is: 'curiosity heightens introspection and stimulates a new way of searching for influences' (Levitt and Williams 2010: 342). The idea here is that facilitating client



curiosity is an activity that is likely to be helpful for most clients, but can be achieved in many ways: defining it at the level of a principle leaves the therapist a great deal of scope in respect of how they might seek to adhere to it.

A case study by Hamm and Leonhardt (2016) illustrates how this works in practice. The therapist in this case was seeing clients in an in-patient facility for individuals who lived in the shadow of long-term schizophrenia. He was part of a network of therapists who had sought to identify the key principles of what was helpful for this client group. They had arrived at three main principles: establishing and maintaining authentic interpersonal connection; helping the individual to tell their personal story in a way that allowed them to feel heard; and encouraging reflection or metacognition that would enable meaning to be found in confusing events and memories. The case report by Hamm and Leonhardt (2016) very sensitively describes how orienting the therapy around these principles offered a highly damaged older female client a therapeutic space within which she could gradually come to recover her sense of self, and begin to build a more satisfying life.

### Box 20.3: The permeability of therapy traditions

Approaches to therapy differ in the extent to which they are open to new ideas. It seems clear that CBT has a highly permeable boundary, in terms of being open to influence from other therapy traditions. Indeed, one of the founders of cognitive therapy and CBT, Aaron Beck, is reputed to have asserted that, 'if it works, it's CBT'. Another approach that has been consistently hospitable to ideas from elsewhere has been transactional analysis (Tudor 2002) – the archive of the *Transactional Analysis Journal* includes articles describing how to assimilate almost every known therapy concept and technique into the TA theoretical framework. By contrast, there has been a tendency for psychodynamic and person-centred approaches to be less welcoming of ideas and methods from other approaches, even though psychoanalytic concepts, and Rogers' understanding of the qualities of a facilitative therapeutic relationship, are universally known, and have demonstrably influenced theorists and practitioners within other traditions.

## Unified psychotherapy

For several years, a group of psychologists and therapists in the USA have been working on an ambitious project to construct a unified theoretical model within which all theories of therapy, and all therapy interventions, can be accommodated (Anchin 2012; Magnavita 2008). Much of this work can be found in the on-line *Journal of Unified Psychotherapy and Clinical Science*, established in 2012. A key element of this endeavour has been the organisation of theoretical constructs into four levels or domains: intrapsychic-biological, interpersonal-dyadic, triadic-relational, and sociocultural-familial (Magnavita 2008). Another area of work has seen the classification and documentation of interventions within a wiki-type platform, *Psychotherapedia* (Magnavita 2008; Marquis 2009). Practical applications have included a comprehensive intake assessment protocol (Marquis 2008) and a model for identifying evidence-based interventions that might be used in response to specific 'markers' of client functioning or distress (Constantino et al. 2013). The unified psychotherapy programme is part of a broader movement to achieve greater conceptual unification across the field of psychology as a whole (Melchert 2016).

## A common language for therapy

The project to establish a unified psychotherapy comprises a deliberate effort, on the part of a group of therapists and researchers, to create a single framework within which all therapy can be practised. A similar process is taking place, but not in a consciously organised fashion, in relation



to the gradual emergence of a common language for therapy. Within the therapy literature, it is possible to find an ever-expanding set of concepts that are not grounded in any specific theoretical model. Examples of this trend include such concepts as alliance, assimilation of problematic experience, collaboration, dialogue, feedback, responsiveness, rupture, and self-disclosure. The extent to which these terms have permeated professional therapy discourse can be confirmed by checking them out in the index of this book. There are also terms such as empathy that have migrated out of a single theory (in this case, client-centred) and are now used by everyone. When a word or concept is utilised by therapists from different theoretical backgrounds, what happens is that a literature is generated that has the potential to allow the concept to be viewed through many different lenses, allowing for a deeper and more comprehensive understanding.

## Collective integration

A form of assimilative integration that is seldom discussed in the literature, but which has a great deal of potential, is *collective integration*. One version of this integrative strategy relates to situations in which groups of counsellors or psychotherapists work closely together, and reach a point of developing a joint approach that is informed by the diversity of personal and professional backgrounds, training experiences, and theoretical interests of members of the group. A good example of collective integration is the work of the Just Therapy Team in New Zealand (Waldegrave et al. 2003). Another example of collective integration is the approach to bereavement counselling for people with learning disabilities developed by a group of counsellors in England (Read 2007). It is likely that there are many collaborative initiatives of this type that have never been publicised, either because the group of practitioners did not ever reach a stage of defining or articulating their approach in formal terms, or because they did not believe that there would be an audience for this kind of writing that describes 'local knowledges'.

A different type of collective integration occurs when a therapy organisation or service provides clients with a range of different services. For example, some in-patient clinics, therapeutic communities, and community agencies might offer individual talking therapy, art therapy, complementary therapies, and many other activities. Sometimes these activities are structured in terms of a programme the client is expected to follow. In contrast, the client might pick and choose around which activities seems most relevant to them at a particular time. What makes such services integrated or integrative (rather than just a therapy marketplace) is that there is some kind of overview of what the client is doing, for example a keyworker or coordinator with whom they can discuss their involvement in different activities, or a shared philosophy or meta-theory that spans the various therapy providers.

## Pluralism

A pluralistic perspective on counselling reflects a position that there are many plausible ways of doing therapy, and many different change processes that can be helpful for clients. A pluralistic approach therefore seeks to find ways to make use of the widest possible range of therapeutic strategies, with the aim of identifying what works best for each individual client. A pluralistic stance not only recognises a multiplicity of valid therapeutic approaches, but also acknowledges the role of a multiplicity of ways of integrating these approaches. Pluralism can be regarded as a meta-perspective, which builds on the strengths and limitations of each of the integrationist models discussed in this chapter. The implications of pluralism, as a guiding framework for counselling training, practice, and research, are explored in the next chapter.

## 'Adapted' approaches to therapy

Earlier sections of this chapter have discussed integration in relation to *theory*: how to bring together ideas, theories, and concepts from different therapeutic traditions. A different type of integration

involves taking account of aspects of human life that have been omitted from mainstream psychotherapeutic approaches and theories. In adopting a largely psychological and individualised perspective, the main 'brand name' therapy approaches that developed during the twentieth century (psychodynamic, CBT, person-centred) constructed ways of understanding people that ignored some dimensions of human existence, such as social class, gender, the body, cultural identity, and spirituality. One of the main challenges for the counselling and psychotherapy profession at the end of the twentieth century and into the twenty-first century has been to devise ways to re-integrate these dimensions into therapy theory, training, research, and practice. The nature of these challenges, in relation to social class, gender, the body, spirituality, and cultural identity, are discussed elsewhere in this book. Typically, these integrative initiatives make use of the concept of 'adaptation', as in culturally adapted or spiritually adapted therapy.

## Conclusions

Beyond current debates on integrationism in therapy, there lies a broader historical perspective. The intellectual history of counselling and psychotherapy is not extensive: psychoanalysis is about 100 years old, humanistic approaches have been around for 60 years, and cognitive models came on the scene less than 40 years ago. The founders of an approach, and their first generation of students, usually need to fight to establish the distinctiveness and uniqueness of their creation. It is only subsequent generations of adherents who become secure enough to make links with other approaches. We are therefore only just entering a period when such collaborations are even possible. This trend has, of course, been complicated and slowed down by the tendency towards splitting and factionalism in the therapy world. But it may well be that we are seeing the beginnings of an emergent consensus over the aims, concepts, and methods of counselling and psychotherapy. Yet, true consensus is only possible when differences are acknowledged and respected. Any profession or discipline that is intellectually alive and socially responsive needs to be able to tolerate a certain degree of creative tension.

It is also essential to recognise that all of the core theories or paradigms within the therapy literature, such as psychodynamic, humanistic, narrative, and CBT, began their existence as integrations or syntheses of ideas and methods with which their founders were familiar. One of the paradoxes inherent in the existence of discrete schools of therapy is that pioneers such as Freud, Rogers, Perls, White, and Beck were individuals who very much worked things out for themselves, and developed ways of doing therapy that were consistent with their own personal style and cultural context. There is a contradiction, then, that their ideas have become fixed systems of therapy that are taught to trainees. If working it out for oneself was a crucial aspect of the professional development of those individuals who were widely regarded as highly effective therapists – the best of the best – it does not quite make sense that such a learning process is routinely denied to those who follow.

It should be clear that, at the present time, there is no single integrative or integrated approach to counselling and psychotherapy. There is, instead, a powerful trend towards finding ways of combining the many valuable ideas and techniques developed within separate schools and approaches. At the same time, however, there are also strong forces within the counselling and psychotherapy world acting in the direction of maintaining the purity of single-approach training institutes, professional associations, and publications networks. This situation is increasingly becoming a battleground in relation to policy-making in healthcare organisations concerning which therapies to make available to clients or patients. There is a lot of research evidence to support the effectiveness of mainstream unitary models of therapy such as CBT and psychodynamic. By contrast, because of the more fluid landscape of integrative therapy, only limited evidence exists of its effectiveness. Policy-makers and managers, influenced by the need to be accountable for their decisions, have up to now consistently opted to favour unitary models of therapy that are backed up by evidence from randomised clinical trials. This has had the consequence, in many localities, of producing a therapy monoculture that

denies choice to service users. One of the emerging challenges for counsellors and psychotherapists who believe in the value of flexible integrated or integrative approaches, is to create organisational structures and research evidence that will enable their voices to be heard.

The following chapter introduces an integrative approach – pluralistic therapy – that has been developed in recent years as a means of building on, and moving beyond, all of the integrative strategies that have been discussed here. The key idea in pluralistic therapy is that the client should be actively involved in decision-making around the types of therapeutic activity that are most beneficial for them.



## Topics for reflection and discussion

- 1 One of the themes that runs through this chapter is around the importance of meta-theory. In order to make choices between different therapy ideas and interventions, it is necessary to apply a meta-perspective that will guide such decisions. What is your own position on this idea? For you, what are the meta-theories that are most meaningful and relevant?
- 2 The existence of non-specific or common factors is a powerful argument in favour of therapy integration. What are the implications of this perspective for the ways that counsellors and psychotherapists work with clients? What are the implications for therapist training?
- 3 Where do you stand on the question of eclecticism and integration? In terms of your own work as a counsellor or therapist, do you find it more useful to keep to one approach, or to combine different approaches? Can you envisage circumstances under which your position might change in the future?
- 4 As a client, does it matter to you whether your therapist follows a single model or uses an integrated or integrative approach? What difference does it make?
- 5 Do you believe that a single unifying theory for all psychotherapies is neither viable nor desirable?
- 6 This chapter has examined some different pathways to integration of therapy approaches. Which of these integration strategies seems most relevant and applicable to you, at this stage in your career? Why?

## Suggested further reading

The classic, must-read book that has influenced a generation of counsellors and psychotherapists to take integration seriously is *The Heart and Soul of Change: Delivering What Works in Therapy*, edited by Duncan et al. (2010). One of the early chapters in the book is based on a fascinating interview with the grandfather of integrationism, Sol Rosenzweig (Duncan 2010). The *Handbook of Psychotherapy Integration*, edited by Norcross and Goldfried (2019), and the *Journal of Psychotherapy Integration* provide comprehensive sources of current ideas about therapy integration. The Society for the Exploration of Psychotherapy Integration (SEPI) holds meetings in many countries. The SEPI website includes an open access newsletter, *The Integrative Therapist*, which carries interesting and accessible brief articles about current developments in therapy integration.

# Chapter 21

## Pluralistic therapy

<b>Introduction</b>	<b>300</b>
<b>Philosophical context</b>	<b>300</b>
The concept of pluralism	300
The moral and ethical dimension of pluralism	301
Ways of knowing	302
<b>The practice of pluralistic therapy</b>	<b>302</b>
Developing a shared understanding: theories as tools	303
Shared decision-making	305
<i>Information</i>	306
<i>Goals</i>	306
<i>Tasks</i>	307
<i>Methods</i>	308
<i>Preferences</i>	308
<i>Collaborative case formulation</i>	308
Maintaining alignment	309
<i>Interpersonal skills</i>	309
<i>Metacommunication</i>	309
<i>Feedback</i>	310
Facilitating learning and change	310
<i>Using existing therapy interventions</i>	311
<i>Experiments</i>	311
<i>Resources</i>	312
<i>Dialogue</i>	312
<b>Pluralistic service delivery</b>	<b>313</b>
<b>Training, supervision, and research</b>	<b>314</b>
<b>Conclusions</b>	<b>314</b>
<b>Topics for reflection and discussion</b>	<b>315</b>
<b>Suggested further reading</b>	<b>316</b>

## Introduction

The previous chapter, on therapy integration, outlined a number of strategies for combining ideas and methods from different models of therapy. Each of these strategies offers a valuable perspective on the dilemma of how to take maximum advantage of the multiplicity of therapeutic ideas and interventions available within established schools of therapy. At the same time, each of these integrationist approaches offers only a partial solution to this dilemma. For example, assimilative integration focuses on the process of professional learning and development of the therapist, while various types of theoretical integration concentrate on how to combine different ideas and concepts. Eclecticism is oriented towards the question of how to choose between different interventions, with relatively little regard for theory. In recent years, *pluralistic therapy* has emerged as an integrative approach that allows existing ideas and methods to be brought together in a flexible and coherent manner.

Pluralistic therapy is based on three key principles. First, it accepts that a wide range of helpful change processes exists different people are helped in different ways. Second, effective therapy is grounded in a moral and ethical stance that reaches beyond professional ethical issues such as confidentiality and informed consent. Third, clients possess their own knowledge about what is helpful (or otherwise) for them: the selection of theories and interventions appropriate to any specific case needs to emerge from engagement in dialogue and shared decision-making in which the client is an active participant. The present chapter provides an introduction to the theory and practice of pluralistic therapy, and explores the implications of this perspective for training and research.

## Philosophical context

The use of meta-theory represents a key aspect of most approaches to therapy integration. The huge array of therapy concepts and interventions that exist within established models of therapy can be viewed as similar to pieces of a jigsaw or mosaic. Choosing the one that fits best requires access to some kind of overarching image or design principles. A variety of meta-theoretical perspectives have been used by proponents of different types of integrated or integrative therapy. Technical eclecticism relies on scientific knowledge to guide treatment choices. Within theoretical integration, meta-theories that have been adopted include the bio-psycho-social paradigm used in many healthcare settings, the concept of choice, various developmental frameworks, and politically oriented meta-theories such as feminism, social justice, and multiculturalism. While each of these meta-theoretical stances has been shown to be effective in guiding therapeutic choice-making, adopting any one of them has the inevitable consequence of downplaying the others. Pluralistic therapy resolves this difficulty by adopting a meta-perspective – the concept of pluralism – that has its roots in philosophy rather than in psychology or in any of the social or health sciences, and offers a meta-theoretical stance that is concerned with the nature of knowledge and the processes of knowing that underpin all practical activity.

## The concept of pluralism

Pluralism is a philosophical concept that refers to the idea that there is no single truth. Pluralists argue that, in any significant dimension of human affairs, there are always multiple plausible ways of understanding and explaining what is happening. From a pluralistic perspective, human culture and history are characterised by ‘dissensus’ – a continual debate or dialogue between individuals and groups who espouse different beliefs or theories about what is ‘true’ or ‘right’. Pluralism can be contrasted with ‘monism’, the position that there is a single theory to which all theories can ultimately be reduced.

The question of the adequacy of monism or pluralism as ways of making sense of the world has been a key issue throughout the history of philosophy. It is clear that human cultures have tended to adopt definite ideas about what is ‘true’, for example predicated on the assumption of a single Supreme Being. More recently, modern science operates according to the assumption that, ultimately,

a single agreed set of 'laws of nature' will be identified. On the other hand, the early Greek philosophers developed a powerful tradition of *scepticism*, which was grounded in the premise that it is not possible to establish, beyond doubt, the truth of any particular statement.

It can be argued that we are living in an era that is characterised by general recognition of the value of pluralism as a guiding principle for human affairs. There are two strong arguments in favour of pluralism. The first argument was articulated by William James (1842–1910), the American philosopher and one of the founders of modern psychology, in a book titled *A Pluralistic Universe* (1909/1977), based on a set of lectures at the University of Oxford in 1908 and 1909. In these lectures, James set out the case for pluralism, and in particular emphasised the point that if a theory represented an absolute singular truth, it would imply that it could not be improved or changed, because any new ideas would need to come from a competing theory (which could not be a source of valid ideas, because if it was valid, it would have already been part of the primary true theory). Given that theories do evolve and change, the monist idea that there can be a single truth is therefore unsustainable.

The other strong argument for pluralism arises in the field of moral philosophy, in relation to the right of people to hold different beliefs. Events in recent history, such as the extermination of indigenous populations following European expansion into America and Australia, the Holocaust, the Gulag, and the Rwandan massacre, have illustrated the implications of adopting a radical monist position in respect of cultural belief systems.

In exploring the meaning of the idea of pluralism, philosophers are generally agreed that it is important to make a distinction between pluralism and relativism. The concept of relativism refers to the idea that everything is true, depending on the context. Relativism is an expression of 'indifferentism' ('it does not matter what you believe') and scepticism ('nothing is true'). However, indifferentism and scepticism are not credible as descriptions of the way that human beings function. On the whole, individuals tend to hold strong beliefs around what is 'true' and 'right', at least in relation to some aspects of their lives. In addition, it seems clear that human progress is not fuelled by people who are sceptical and indifferent, but by those who have a passionate commitment to a particular theory. It is therefore unsatisfactory to equate pluralism with relativism. Instead, this line of argument leads to the hugely challenging conclusion that pluralism implies a willingness to (a) possess strong beliefs about what is true, while at the same time (b) accepting that the different strong beliefs held by other people are also true. In effect, pluralism implies *dialogue* – adopting a pluralistic perspective requires a willingness to build meaning-bridges between one's own strong held truths and the truths that are held by others.

In summary, the concept of pluralism suggests that there is no single truth to which we can aspire, and that it is more effective to base our lives on a willingness to be open to multiple perspectives on a problem. In terms of decision-making and problem-solving, pluralism invites a 'both/and' approach rather than the adoption of 'either/or' strategies. Finally, in the domain of social life, pluralism highlights the importance of constructing opportunities for dialogue (conversations between people who are open to each other, make good faith attempts to understand each other, and are willing to express their own positions as fully as they can, and to allow these positions to shift in response to new ideas). In this context, dialogue can be contrasted with debate (trying to persuade the other person that you are right and they are wrong).

This overview of pluralism can do no more than indicate some of the key aspects of philosophical thinking around this concept. The most accessible source of further discussion of the meaning of pluralism is Rescher (1993). Beyond that, other useful philosophical perspectives can be found in Ferrara (2010), Goertzen and Smythe (2010), Irving and Young (2002), McLennan (1995), and Stone (2006), and in a special issue of the *Journal of Mind and Behaviour* (Slife and Wendt 2009; Woody and Viney 2009) published to mark the hundredth anniversary of *A Pluralistic Universe*.

## The moral and ethical dimension of pluralism

The practice of any kind of counselling or psychotherapy is carried out with reference to ethical rules and principles that are defined and enforced by professional organisations and/or the legal system. All professions need to make sure that harm does not come to clients, service users are



treated fairly and with respect, that the safety and welfare of children and vulnerable adults is taken into account, and so on. Pluralistic therapy goes further than this, by seeking to include ethical awareness into the actual practice of therapy by drawing on ideas from the field of *relational ethics* (Gabriel and Casemore 2009; McLeod 2017a).

Relational ethics involves a willingness to accept what the existential philosopher Emmanuel Levinas has characterised as the ‘otherness of the Other’ – responding to the person as a unique being rather than as an ‘object’ or a ‘case’ or assuming that they are the ‘same’. This is not easy (Sayre 2005; Whiting et al. 2005). For example, in practice, this kind of ethical stance requires the therapist to be open to learning from the client. In addition, if a therapist is to engage in dialogue, they need to be willing to be known (e.g. to share their ideas and their areas of uncertainty). These commitments can seem quite risky, because they involve moving beyond an expert role and into a zone of uncertainty.

A further dimension of relational ethics arises from an appreciation that the client is a member of a society that is marked by injustice, oppression, exploitation, and cruelty. As a result, effective and respectful therapy may involve talking about the client’s experience of oppression, both as a victim and a perpetrator. This aspect of therapeutic work has been described as a *social justice* orientation (see Chapter 26). A distinctive feature of pluralistic practice is a willingness to engage in dialogue around social issues, values, and political action. Taking pluralism seriously requires seeing the person, and oneself, not merely as a psychological or biological entity, but as a participant in social, cultural, and political life. Relational ethics also highlights the significance of the concept of *care*, encompassing a willingness to say that you care, and to question any signs of absence of care.

## Ways of knowing

A further aspect of the philosophical context of a pluralistic perspective is that it implies the existence of multiple ways of knowing. In making their way through life, and within therapy sessions, clients and therapists draw on different domains of knowing – personal, cultural, practical, theoretical, and scientific (McLeod 2017a). These domains of knowing are intertwined with different styles of thinking and problem-solving, such as rational, artistic, kinaesthetic, action-oriented, musical, and so on. In pluralistic therapy, one of the implications of awareness of the existence of multiple ways of knowing is sensitivity to different learning styles. For example, some clients may want to talk, some might prefer to read, others to watch movies or YouTube clips, while yet others will find it most meaningful to create diagrams.

Taken as whole, the nature and meaning of the concept of pluralism, as a philosophical idea, provides pluralistic therapy with a meta-perspective that is not grounded in any single therapy theory, or specific set of ideas within psychology or any other discipline. Instead, it offers a platform from which it is possible to make use of all areas of knowledge that are relevant and meaningful to the client and therapist.

## The practice of pluralistic therapy

If there are many ways that people can change, and many therapeutic activities that can be helpful, the question then arises: how it is possible to identify the ideas and activities that are most suitable for an individual client? It is in its response to this question that pluralistic therapy adopts an approach that is fundamentally different from other integrationist models of therapy. Instead of relying on a pre-planned integrated model, or on the clinical judgement and experience of the therapist, a pluralistic approach advocates that the best ideas about how to move forward in therapy will emerge from a process of collaboration, dialogue, and shared decision-making between client and therapist.

In many types of therapy, dialogue and collaboration are treated as general processes or principles that function as elements in a good therapeutic relationship or alliance. By contrast, in pluralistic

therapy these elements are brought into the foreground and defined in terms of a set of skills and procedures implemented by the therapist. The aim is to build a creative space within which the best ideas of both the client and therapist can be brought together to design a therapeutic process that is tailored to the needs and preferences of the client.

To construct a pluralistic therapeutic space, a therapist needs to have internalised a pluralistic perspective on life, and to operate from a pluralistic way of being. In other words, their openness to the Other and to a process of dialogue needs to be genuine and a part of their own life. Then, from such a stance, the therapist pays attention to key moments in therapy that function as ‘markers’, ‘openings’, or ‘gateways’ for conversations that will enable the collaborative alignment of client and therapist. The following sections describe the main ways in which this occurs.

## Developing a shared understanding: theories as tools

The proliferation, within the literature, of dozens of theories of therapy represents both a challenge to pluralism and an opportunity. The challenge to pluralism lies in the extent to which supporters of specific theoretical approaches operate from a monist position in which they assume that their own model is ‘true’ or ‘effective’, and other approaches are mistaken and ineffective. Because a large proportion of counselling and psychotherapy training and research is organised around competing ‘schools’ of therapy, many practitioners have been socialised into believing that their way is the right way. This tendency is reinforced by the existence of professional associations consisting solely of people who have been trained in a specific theoretical approach, and research studies that aim to provide evidence for the unique effectiveness of that approach. Within these single-orientation groups, there may be some form of ‘internal pluralism’, for example in the form of dialogue between contrasting versions of psychoanalysis, or CBT, or person-centred theory. Most of the time, brand-name schools of therapy operate like renaissance city-states, asserting their status and seeking to gain an advantage over their rivals. On the whole, the counsellors and psychotherapists who operate within these enclaves may have relatively limited contact with colleagues from other approaches, and are unlikely to read the work of writers and researchers who are based in different traditions.

At the same time, the proliferation of therapy approaches represents an opportunity, because it has created a situation in which clearly articulated theoretical statements are available regarding ways of making sense of how problems develop, how they are maintained (i.e. what prevents change), and how learning, healing, and change can take place. This is important because, usually, a therapy client (or anyone else for that matter) struggling with a problem in living will be searching for a handle on their difficulties – some way of bringing things into perspective.

In pluralistic therapy, theories of therapy are regarded as tools for understanding. In a valuable series of papers, Hansen (2004, 2006a, 2006b, 2007) proposed that it is not helpful to regard therapy theories as being similar to scientific theories that allow scientists and technologists to predict and control aspects of the world. Instead, therapy theories function as narrative structures, that allow different types of story to be told about how problems develop and how they can be handled. Theories are therefore useful not because they embody objective truth but because they equip the therapist with narrative templates that the client can ‘try out’ in the process of making sense of their problems (Hansen 2006a).

In philosophical terms, what Hansen (2007) is advocating is the adoption of a *pragmatic* stance in relation to therapy theory (see also Fishman 1999). The client is looking for a way of making sense of their problems, and theories of therapy provide a stock of possible narrative story-lines that can be tried on for size. It is possible that the client will not find an ‘off-the-shelf’ theory that suits them, but will end up fashioning a bespoke, synthesised, or personalised theory that meets their needs at the time and sufficiently reflects their values and worldview. From this perspective, therapies theories can be viewed as resources or tools for understanding.

In pluralistic therapy, the importance for the client of the struggle to make sense of their problems is met with interest and curiosity on the part of the therapist around the client’s personal theories.

For example, the therapist might say something along the lines of: ‘I can see that you have been trying to deal with this depression for a long time – how do you make sense of it, yourself? What are your ideas about what has caused it, and what might help?’ At the same time, the therapist offers the client their own way of making sense, in a tentative manner that indicates that the therapist is open to the possibility that their ideas may not fit with the way that the client sees things. The therapist may also work to create bridges between different ways of understanding espoused by the client and therapist. The development of a sufficient degree of shared understanding allows the client and therapist to know that they are on the same wavelength when discussing other aspects of therapy. In some situations, clarity around how to make sense of a problem, being introduced to a new way of making sense, or shifting from a state of confusion to a state of possessing concepts that allow an issue to be thought through – all of these accomplishments can be helpful for clients.

### Box 21.1: Using theory – a pragmatic perspective

How do counsellors and psychotherapists use theory on a day-to-day basis? Polkinghorne (1992) interviewed several experienced therapists, and carried out an analysis of books on therapy practice. He found that although therapy theories were seen to function as useful models and metaphors that could be of assistance in ‘constructing cognitive order’, there was no sense that any theory could ever capture the complexity of human existence. These therapists were comfortable with the diversity of theories that existed in the literature, and felt that their theoretical knowledge was unfinished – an ongoing journey. Their main criterion for assessing the value of a theoretical idea was pragmatic – does it work?



### Case study 21.1: Pluralistic therapy in action – developing a shared understanding

B had been living with HIV for 11 years and was experiencing some persistent health conditions that affected his quality of life. He received counselling at a therapy organisation that offered a maximum of 12 sessions. At the start of counselling, B identified his therapeutic goals: greater balance in his relationship with his partner and the opportunity to make sense of some traumatic experiences. In early sessions, his counsellor invited him to share his ideas about how therapy might be helpful for him. Drawing on some previous experience of therapy, which had not been ideal for him, B stated that he wanted space to explore, he did not want to be challenged, and he wanted to be the expert in the room.

B’s counsellor was female, with a primary training in humanistic approaches and a commitment to working in a pluralistic way that reflected the client’s sense of what was helpful. For the most part, the counsellor adopted a non-directive, empathic way of being with the client, as a means of allowing him to be the expert and to have the ‘space’ that he needed. B identified some specific therapeutic activities that he believed would be helpful for him: writing his memoirs and constructing a time-line of his life. When the counsellor became too challenging or directive, B was able to tell her that what she was doing was not useful for him, and she was able to change her emphasis. In feedback sessions after the end of counselling, B reported that therapy had been helpful for him, and he had accomplished most of what he had hoped to achieve. The case of B offers an example of how a client was able to teach a counsellor what he needed, and the counsellor in turn was able to create an environment and a relationship that the client was able to use to benefit from.

A more detailed account of this case can be found in Miller and Willig (2012).

## Shared decision-making

The use of shared decision-making has received a great deal of attention in the fields of medicine and healthcare. Patients have their own ideas about what will help them, as well as clear preferences around such issues as the timing of treatment and how much discomfort they are willing to tolerate. For example, while physicians have been mainly trained to prescribe medication and surgery, many patients may be convinced of the value of complementary therapies and indigenous healing practices that do not fit readily into a mainstream medical model of practice. The medical profession as a whole has recognised that effective treatment needs to be a partnership with the patient and that resources can be wasted (e.g. medication not taken, missed appointments) if the patient is not convinced that the treatment package is right for them. Time is at a premium in doctor–patient or nurse–patient consultations, patients tend to view doctors and nurses as experts who will tell them what to do, and medical decisions are typically based on complex technical information. Because of these factors, it has proved useful in healthcare settings to augment shared decision-making conversations with pre-prepared, structured decision-making tools such as information sheets or videos and step-by-step guidelines regarding which topics need to be discussed and in what order. An introduction to the ways in which healthcare professionals think about shared decision-making can be found in Mulley et al. (2012) and Stiggelbout et al. (2012, 2015).

There are many ways in which shared decision-making in counselling and psychotherapy differs from that in nursing and medicine. For example, it is usual for a conversation to take place between doctor and patient during an early consultation that focuses on deciding a course of treatment that will then be implemented. Something similar may happen at the start of counselling and psychotherapy, for example at an intake or assessment meeting, around deciding the model of therapy to be used, the gender of the therapist, and the number and timing of sessions. However, counselling and psychotherapy also involve a process of continuous micro-decision-making around which topics and tasks to pursue in a particular session. There is also a sense in which the actual making of a decision is in itself a therapeutic process. For example, with a client with alcohol misuse issues, the decision around whether to be abstinent or engage in limited drinking may lie at the heart of the therapy. There are other therapy scenarios, for instance with individuals who are perfectionist, where the act or experience of making a decision is one of the main problems that the person brings to therapy. In addition, the experience of engaging in a process of shared decision-making with another person (i.e. the therapist) may be a crucial learning experience for the client.

There are several reasons why shared decision-making is an integral aspect of pluralistic therapy. First, it is assumed that the client has reasons for entering therapy, in the form of a set of goals. Shared decision-making ensures that the therapy is oriented towards the accomplishment of the client's goals. Second, the client has ideas about what will help (or not help). Shared decision-making involves discussing and making choices around therapy activities that the client views as potentially useful, and that are within the competence of the therapist to deliver. Third, shared decision-making reflects an ethical commitment to treating the client as an autonomous, purposeful, informed, and aware person. Fourth, consciously and intentionally marking off episodes of shared decision-making ('remember when we agreed to . . .') makes it possible to revisit and revise such decisions as necessary. Such a strategy also gives the client the sense that the therapist knows what they are doing, and confidence that their own views and responses are being taken seriously. Finally, engaging in a process of shared decision-making has the potential to enable the client to develop collaborative decision-making skills and awareness that can be applied in everyday life contexts.

In broad terms, the process of shared decision-making in pluralistic therapy involves a series of steps. The client is supplied with relevant information about the options for therapy. Information is elicited about the client's preferences, such as that arising from previous knowledge and experience of therapy, as well as in response to the 'menu' of options provided by the therapist. There is a

discussion about the client's problems and their goals for therapy. These early steps feed in to a collaborative case formulation episode, where the client and therapist work together to map out their shared understanding of how the client's problems developed, and the specific tasks and methods through which their therapeutic goals might be achieved.

In practice, these steps may not follow a neat sequence. For example, a client may feel a strong need to use early sessions to tell their life story in great detail, express emotions, or check out the trustworthiness of the therapist. Also, it may take time for clients to clarify and articulate their goals and preferences.

### *Information*

The ethical practice of therapy is based on a principle of informed consent – it is the responsibility of the therapy organisation, and the therapist, to ensure that the client fully understands what they are committing to, what the risks are, and the availability of alternative sources of help (O'Neill 1998). Providing the client with information, and opportunities to ask questions, is therefore an integral aspect of good practice. A key aim of pluralistic therapy is to engage the client as a partner and active participant in the process of tailoring therapy to their needs and preferences. This involves more than what is required for ethical informed consent. Ideally, a client will become actively curious about whatever it is that troubles them, and how their problems can be effectively addressed (Levitt and Williams 2010). The purpose of information is to provide the client with ideas and strategies that they can take on board and apply in their lives. For example, pluralistic practitioners prepare information sheets and copies of relevant articles that the client can read, recommend books and videos, check out what the client already knows, invite the client to ask questions, encourage the client to consult with other people who possess relevant knowledge and experience, and take time to explain the process of therapy. Useful examples of how these activities can be helpful can be found in the CBT and self-help literature. A distinctive feature of using information within a pluralistic way of working is an emphasis on offering multiple perspectives, rather than just providing material based on a single model. The intention is to create a space within which the person can reflect on different possibilities in order to find what fits best for them.

### *Goals*

A shared understanding of what the client wishes to gain from therapy – their goals – is a key element in pluralistic therapy. While the client and therapist may be open to considering the relevance of a wide range of ideas and activities, this should never become an abstract intellectual exercise – the ultimate test is whether these processes contribute to positive movement towards accomplishing goals. In addition to the practical value of a goal-oriented approach, conversations and awareness around goals also reflect an appreciation, from existential philosophy, that human beings exist in time, and are always in a process of becoming. The significance of *directionality* as an essential aspect of human existence, and how this underpins many different types of therapeutic work, is explored in Cooper (2019). Goals conversations in pluralistic therapy therefore have the effect of inviting the person to consider their future, in terms of who they want to be and what they want to achieve. It can be helpful, in facilitating such conversations, to be sensitive to the difference between specific therapy goals and wider life goals (Mackrill 2010). Many pluralistic therapists ask their clients to complete goal attainment rating forms that are used to clarify goals, document when and how goals might shift over the course of therapy, monitor whether progress is being made towards goal accomplishment, and provide feedback to the client and therapist on these topics. Goals rating forms are typically brief and require the client to reduce what may be multifaceted life projects and subtle threads of meaning to a number on a scale. It is necessary, therefore, for the therapist to operate from a position of understanding the complexity of goals, including unconscious goals and difficulties admitting certain goals into awareness or expressing them in a conversation with another person. Conceptual and practical aspects of working with goals are discussed in Law and Cooper (2017).



## Box 21.2: Sensitivity to the use of language

Pluralistic therapy seeks to find ways to select, personalise, and tailor therapy theories and interventions so that they connect with the experience of the client. This theme includes sensitivity to the use of language. It is important for a client and therapist to find ways of talking that make sense to them. While pluralistic therapy includes a number of technical terms, such as goals, metacommunication, and collaborative case formulation, these are chosen because they make it easier for the therapist to access discussion and research on these topics within the professional therapy literature. However, these may not be words that resonate with a particular client or therapist. For example, the idea of having a 'goal' can be conveyed through many other words and images: making, building, or constructing something; being on a journey to a destination; growing; having intentions or wishes; imagining a future; pursuing a project, and so on. Bilingual clients may have an even richer repertoire of words and images on which they can draw.

### Tasks

Although the client's goals provide the anchor-point for pluralistic therapy, it is seldom possible to work directly on a goal. For example, if a client identifies a goal of 'being less depressed', it is hard to know where to start. There is no one specific intervention that will reduce depression – even medication, at best, will only make a difference around mood and energy levels, and is unlikely to touch issues such as the meaning of life, relational withdrawal, or self-criticism. Within pluralistic therapy, the concept of 'task' is used to refer to subgoals that can be the focus of sustained therapeutic work. For instance, with a client who wishes to use therapy to feel less depressed, it might be helpful to identify achievable tasks such as finding ways to feel more energetic, experiencing more positive emotions, reducing or eliminating a harsh self-critic, developing a wider range of social contacts, and so on.

As a first approximation of the kinds of tasks that may be relevant, it may be useful for the client and therapist to consider the relevance of a list of generic, frequently occurring therapeutic tasks, such as:

- exploring and dealing with difficult emotions;
- exploring and addressing self-undermining ways of thinking;
- developing more satisfying ways of relating to others;
- understanding the significance of adverse past events and experiences;
- making sense of events and experiences that are troubling and confusing;
- negotiating a life transition;
- collecting and evaluating information ;
- making decisions and choices;
- planning and implementing behaviour change;
- finding new sources of meaning in life.

The tasks that are defined and agreed in any particular case are likely to be a variant, adaptation, or fusion of the tasks listed here – the aim is to agree on tasks that are personalised and meaningful to the client at that point in their life. From the point of view of the therapist, tasks represent areas of competency. A therapist should be confident that they are capable of tackling any one of these tasks. In some instances, a therapist may possess a high level of expertise in respect of a task. For example, a therapist who has interests or training in CBT will be very comfortable when working with the client around addressing self-undermining ways of thinking, or planning behaviour change. A therapist with interests and training in existential or constructivist therapy will similarly be very comfortable



with meaning-making tasks. However, any therapist should possess sufficient interpersonal skills, basic counselling skills, and relevant personal life experience to be able to join with their client in tackling any of these tasks. The notion of a task list can also provide a focus for training and practice in relation to the needs of particular groups of clients. For example, clients who have long-term physical illnesses may need to work on difficulties in relationships (e.g. being assertive) with doctors and nurses, while career counsellors need to develop expertise in working with clients around life transition issues and making choices.

### *Methods*

In pluralistic therapy, the concept of 'method' refers to any activity whose purpose is to contribute to the accomplishment of a therapeutic task, and there are many methods that can be used in therapy (Mahrer 2007a). Clearly, therapy approaches have generated a large number of exercises, techniques, and interventions. Individual therapists have invented many therapeutic activities and strategies, some of which they keep to themselves, but sometimes may disseminate to colleagues (see, for example, Carrell 2001; Yalom 2002). Finally, there are many therapeutic activities – in pluralistic therapy, described as cultural resources – that exist within the culture and society inhabited by the client and therapist. For example, people who are depressed may find it valuable to make use of cultural resources such as walking in the hills, making music, making art, cooking, engaging in spiritual practice, and many other activities. In pluralistic therapy, the aim is to work collaboratively with the client to find the best method, for them, in relation to working on a task. The method may be suggested by the client or the therapist, or emerge on a trial-and-error basis from their shared efforts to try out 'prototype' solutions in relation to specific tasks (McLeod 2017a).

### *Preferences*

A pluralistic approach to therapy emphasises the significance of client *preferences* (McLeod 2012). For several decades, counselling and psychotherapy researchers have investigated various aspects of how clients perceive therapy, using constructs such as attitudes, beliefs, expectations, and credibility. More recently, this line of inquiry has refocused around the notion of 'preference', in recognition of the idea that the client draws on their beliefs and attitudes to make an active choice around how far they are willing to engage with different aspects of the therapy process, or with different therapeutic techniques.

Research findings suggest that client preferences have a bearing on the outcomes of therapy in two main ways. First, when what happens in therapy matches the client's preferences, there are lower rates of drop-out and unplanned ending (Swift and Callahan 2009). Second, clients who are offered a preferred way of working are more likely to benefit from therapy, in terms of problem reduction and attaining therapeutic goals (Berg et al. 2008). A detailed discussion of this area of research, and its implications for practice, can be found in McLeod (2012, 2013b). One of the most interesting aspects of this research is that it is clear to most practising therapists that, on the whole, when clients are asked at the start of therapy to describe their preferences for how they think their problem might best be approached, they tend to be quite vague in what they say. What the research shows, however, is that, given a simple preference questionnaire to fill in, the relatively vague and uncrystallised ideas that are in the client's mind do have significant predictive value. In addition, there is evidence that clients respond positively to encouragement and space, at the start of therapy, to talk about their preferences (Vollmer et al. 2009; Walls et al. 2016).

### *Collaborative case formulation*

In pluralistic therapy, collaborative case formulation is used to bring together the various strands of shared decision-making – information, goals, tasks, understanding, preferences, and methods. Collaborative case formulation draws on ideas about a substantial research and practice literature that exists around the areas of case formulation and case conceptualisation (Eells 2015; Johnstone and Boyle 2018; Johnstone and Dallos 2014; Kuyken et al. 2009; Meehan and Guilfoyle 2015), as well as individualised assessment (Finn and Tonsager 1997; Finn et al. 2012; Fischer 2000).

Collaborative case formulation will take place near the start of therapy. The timing and format of this therapeutic activity depends on the preferences and priorities of the client and therapist. Many pluralistic therapists create a timeline diagram, co-constructed with the client (McLeod and McLeod 2016). The use of visual representation makes it possible to capture the complexity of the client's life, and the existence of the formulation as a tangible entity (a drawing on a large sheet of paper) externalises the client's issues in a way that encourages reflection. The formulation may be revisited and revised as necessary during future sessions. By the end of the initial formulation session, the intention is that the shared understanding between client and therapist has been checked out, clarified, and strengthened, and they have a clear sense of shared purpose about what to do next. If possible, the patterns of connection between life-events that the therapist maps out in the formulation will offer the client at least three alternative perspectives on their issues. For example, the client may be invited to consider the origins of their difficulties in events during childhood development, in relation to family dynamics, as a consequence of dysfunctional cognitive processing, and so on. The process of case formulation therefore provides the therapist with an opportunity to draw on different therapy theories in a manner that is tailored to the circumstances and understanding of the client, while also creating opportunities to elicit and explore the personal theories of the client.

## Maintaining alignment

It is the responsibility of the therapist to maintain alignment between themselves and the client. Alignment refers to a sense of moving in the same direction, or thinking along similar lines. Alignment is necessary if genuine collaborative work is to take place. If the ideas and personal knowledge of each participant are to be effectively brought together to address therapeutic tasks, the client needs to be aligned to the therapist, and the therapist needs to be aligned to the client. This is accomplished through three main processes: interpersonal skills, metacommunication, and feedback.

### *Interpersonal skills*

Good therapists are able to use a wide range of interpersonal skills and counselling skills that have the effect of maintaining alignment with the client. One of the key areas of skill is in the domain of active listening and empathy. Other relevant skills include reflecting back to the client what has been understood, explicitly checking out, and summarising. These are all actions that help both the client and therapist to know whether they are in connection with one another and moving in the same direction. Most of the time in a therapy session, the client is expressing their feelings and talking about problematic experiences, and the therapist responds. At the same time, to maintain connection and shared sense of direction, the client needs to know about the position of the therapist. Because of prior adverse life experiences that have led them to be wary of others, many clients are exceptionally sensitive to the emotions and intentions of their therapist. However, some of this sensitivity may involve the projection of assumptions on to the therapist that do not actually match the therapist's experience. Effective therapists are often highly skilled at letting the client see what is going on for them. This involves what Rogers described as 'congruence' (see Chapter 10) and Mearns and Thorne (2013) characterised as 'showing your workings'. It also resembles various forms of therapist self-disclosure. While most therapists possess this kind of skill-set (otherwise they would not have been accepted into a training programme), the key test is whether they can exhibit these skills in pressure situations – for example, when the client withdraws emotionally, is challenging, angry or flirtatious, or is in a state of deep emotional pain and distress (see Chapter 27).

### *Metacommunication*

Metacommunication can be defined as 'communication about communication': standing back from the ongoing flow of conversation and reflecting on (or inviting reflection on) the intentions and/or reactions of the speaker and/or listener (see Chapter 3). Within a pluralistic approach to therapy, this conversational strategy functions as a means of enabling micro-collaboration on a

moment-by-moment basis. Metacommunication conveys an implicit message that the client has valuable information and insights to contribute, and that the therapist is someone who is open to correction. The use of metacommunication within pluralistic therapy is an example of an integrationist approach. Directly informed by the work of Kiesler (1988) in interpersonal therapy and Safran's (1993a, 1993b) model of the process of repairing ruptures in the therapeutic alliance, it also overlaps with processes such as modelling and facilitating self-observation (Beitman and Soth 2006), here-and-now immediacy (Hill et al. 2014), disclosure of the impact of what the other person has said (Kivlighan 2014), commenting on and drawing attention to the process of therapy (McGrath and Donovan 2013), and transference interpretation (Ulberg et al. 2014). In pluralistic therapy, alongside these other functions, the main purpose of using metacommunication is to make it possible for each participant to share their plans and strategies at specific moments in therapy, and to be aware of the plans and strategies of the other (Rennie 1990). By consistently engaging in metacommunication, the therapist strives to ensure maximum alignment around goals, tasks, and methods, and how issues being explored are conceptualised and understood.

### *Feedback*

A major development in therapy research and practice in recent years has been an increasing recognition of the importance of client feedback in relation to their own evaluation of progress in areas such symptom reduction, goal attainment and recovery, and their views and feelings about the therapy relationship and the approach being taken by the therapist (Miller et al. 2016). Although there are many situations in which it can be valuable to elicit informal verbal feedback from a client, there are advantages in using brief quantitative rating scales and open-ended qualitative forms. These instruments provide the client with a structure for communicating feedback, and reinforce the principle that the therapist takes feedback seriously. Further information on different kinds of feedback tools that can be used in routine practice can be found in Barkham et al. (2015), Duncan and Reese (2015), Lambert (2015), and McLeod (2017b). Feedback on progress towards goals is particularly valuable because it is specifically anchored in the issues that are of most concern to the client (Law and Cooper 2017; Lindhiem et al. 2016; Sales and Alves 2012). In pluralistic therapy, the use of structured feedback procedures provides a way of finding out whether therapy is on track. If the client indicates that some aspect of therapy is not working, then both therapist and client can engage in further shared decision-making as a means of finding a more effective way to move forward together. Feedback is not intended as a source of information that is interpreted and acted upon solely by the therapist in expert role. Instead, the aim is to use feedback as a 'conversational tool' (Sundet 2009, 2012a, 2012b) that stimulates collaborative dialogue between client and therapist.

### **Facilitating learning and change**

In pluralistic therapy, it is the aim and intention of the therapist to make use not only of concepts, techniques, and interventions that have been described and investigated within the therapy literature, or are derived from psychological theory, but to be open to the widest possible range of activities that might be helpful for a specific client. Collaborative pluralism encourages an attitude of therapeutic improvisation – making use of whatever resources are at hand. Pluralistic therapy differs from other forms of therapy in that the implementation of methods for facilitating learning and change is, as far as possible, explicitly negotiated between the client and therapist. Once there is agreement to work on a particular task, the therapist invites consideration of the best way to approach that task. Sometimes the client has a notion of the best way to proceed ('I just need to talk about it', 'it would be helpful to learn how to relax in that situation', 'I need to face up to my fears', 'I think that CBT would help me'). At other times, the client may prefer the therapist to offer suggestions. In such a scenario in pluralistic therapy, the therapist will try to come up with at least three contrasting methods, adding that other strategies might also be feasible as a means of conveying

that the client's active choice is important. Offering multiple options conveys hope: even if none of these methods proves to be effective, there will be a strategy somewhere that will fit. The flow of therapy is therefore punctuated by episodes of metacommunication in which therapist and client are not primarily focused on doing something to address a problem, but instead are talking about the options available to them, and then at a later point reviewing what has been learned from the implementation of whatever option has been tried.

### *Using existing therapy interventions*

The therapy literature includes an endless list of techniques, strategies, activities, and interventions. Pluralistic therapists are curious and open to learning in relation to this body of practical knowledge, and will typically seek opportunities to try out therapeutic activities on themselves. Pluralistic therapy requires a willingness to detach therapy techniques and interventions from the theory in which they are embedded. For example, although two-chair work is widely characterised as a technique associated with gestalt therapy and emotion-focused therapy, it is a strategy that can be used in any form of therapy as a means of sharpening and dramatising internal or interpersonal conflicts experienced by a client. Emotion-focused therapists are exceptionally effective at using two-chair interventions both as a result of the intensive training they have received and the substantial body of theory and research on which that training is based. However, that does not preclude other therapists from making good use of that particular method. Similarly, psychodynamic therapists possess a high level of skills and awareness around the process of transference and countertransference, and are trained in how to use transference interpretation to facilitate client insight. Nevertheless, most therapists are aware of persistent patterns of feeling and behaviour exhibited towards them by a client, and corresponding personal reactions on their part. Many therapists are capable of drawing attention to these here-and-now interactions, even though they are not trained in psychoanalysis or psychodynamic therapy.

For a pluralistic therapist, the capacity to make use of techniques and interventions from established schools of therapy is based on a series of steps. First, it is necessary to adopt a critical, culturally and historically informed stance in relation to therapy theories. A therapy theory such as emotion-focused or psychodynamic is not viewed as a fixed and unchangeable 'truth' but instead as a set of ideas and practices that reflect a particular cultural *zeitgeist*, in conjunction with the personal experiences and interests of a set of founding figures. Second, a pluralistic therapist needs to be able to dismantle a therapy approach into its constituent parts. One way of doing this is to think about a therapy theory in terms of common factors and change processes: which bits of the model are designed to promote which common factors or change processes? Third, they develop a personal understanding of the parts that are relevant to them. This involves understanding the various situations or client markers in which an intervention (e.g. transference interpretation or two-chair work) might be appropriate, and which change processes might be potentially facilitated by its use. A key aspect of this step is that most interventions and techniques have the capacity to lead to change processes beyond those envisaged by their inventors. For instance, although the emotion-focused literature portrays two-chair work as a means of facilitating emotional change, it can also enable client learning in such areas as self-esteem ('I was brave enough to do this'), interpersonal connectedness ('it was a revelation that my therapist was right with me and accepted me even though I became really angry'), and behaviour change ('I realise now how important it is to look at a person while I am talking to them'). The final steps in being able to assimilate a technique or intervention into one's own repertoire is to be able to describe it in common-sense language that can be understood by a client (this is necessary if an intervention is going to be discussed with clients), and to practise and rehearse how the intervention might be used.

### *Experiments*

A collaborative pluralistic framework for practice lends itself to the use of experiments and the design and testing of 'prototype' solutions (McLeod 2017a). Inviting the client to 'experiment'

with a new way of thinking about themselves, or a different way of responding in a situation, is a central aspect of CBT, constructivist and narrative therapies, and many humanistic therapies. There is a crucial difference between an experiment and an experience of practising something. The former is intended as a stimulus to further learning – something important can be learned whether or not the experiment produces the hoped-for result. In the latter case, if practice, such as a therapy homework exercise, does not produce the hoped-for result, the client may feel they have failed, and may seek to hide their failure from the therapist. The way in which pluralistic therapy sessions are structured (agreeing to work on a task, then doing some work, then reviewing the work) provides a context within which mini-experiments can be readily included. This can make it easier for the client to suggest an experiment, because they know they will not feel stupid if it does not prove to be productive. Because a pluralistic therapist has consistently shown a genuine interest in the client's preferences and knowledge, the client may be open to trying out an experiment suggested by the therapist – the therapist has built up a stock of credibility in the eyes of the client.

### Resources

The concept of 'resources' refers to strategies and activities that can be used to facilitate learning and change in relation to a client's goals, or provide support while such activities are being pursued. Implicit in this perspective is the assumption that resourcefulness is a crucial aspect of being able to deal successfully with problems in living, and that resource depletion lies behind many of the difficulties for which clients seek therapy (Hobfoll 1989). The aim is that the therapist (or therapy clinic) is resourceful, models resourcefulness, and works to help the client access resources and generally become more resourceful. In pluralistic therapy, resources refers both to personal strengths (e.g. humour, perseverance, previous experience of overcoming a problem) and to activities outside of the person, such as supportive friends, family members, and work colleagues (Flückiger 2010). Potentially valuable change mechanisms may be found within the *cultural resources* (Cooper and McLeod 2011; Marley 2011; McLeod 2005, 2017a) that are accessible to the person. Cultural resources can encompass a vast array of opportunities for learning and healing, such as education classes, walking in the countryside, meditation, participation in sport, internet-based support groups, watching movies, and much else. A particularly crucial cultural resource, in relation to finding meaning in life and making connection with others, is *art-making* (see de Botton and Armstrong 2013, and Chapter 16). Thinking in terms of cultural resources allows the client and therapist to make use of a community perspective on living a productive life, for instance by drawing on theory, research, and practice into social capital (Halpern 2005; Larence and Porter 2004) and cultural wealth (Walck 2017).

### Dialogue

Most of the time, pluralistic therapy focuses on the stated goals of the client – collaborative work organised around goals, tasks, methods, and shared understanding is intended to find the best possible ways to make a tangible difference to the life of the client. Beyond this, the hope is that the client and therapist can arrive at a stage where they are able to engage in dialogue in which each is open to both self and to the other. Such a way of being together enables what has been described as a 'fusion of horizons' – the emergence of new perspectives and insights that build on but reach beyond the pre-existing awareness of either participant. The value of dialogue has been emphasised by many contemporary writers on therapy (see, for example, Anderson and Gehart 2007; Seikkula and Trimble 2005; Seikkula et al. 2006). Dialogue can occur in fleeting moments of meeting, within segments of therapy, or it can become a reliable and established mode of relating between a client and therapist. The experience of authentic dialogue not only allows for new practical insights to be generated, but may also be experienced as a life-changing and transformative glimpse of how people can relate to each other.



### Box 21.3: Exercise as a cultural resource

Taking exercise is a resource that is available to most people. Walking, jogging, playing sport, dancing – these are all forms of exercise. The physical and mental health benefits of exercise are well established. It can be helpful for counsellors to be interested in the ways that clients take exercise, and to encourage clients to undertake appropriate exercise. Hays (1999) describes several ways in which she, and other therapists, explore the meaning of exercise for clients, and enable them to be more aware of how the effect of exercise can contribute to therapeutic change. For example, a client who is depressed may find that working out at the gym gives him a more positive outlook. A socially anxious and isolated client may find it possible to engage in brief conversations with fellow dog walkers in the park. In these situations, the counsellor is not trying to be a coach or fitness trainer, but instead is working with the client's own strengths and resources. Exercise is not helpful for everyone: if a client is not interested at all in exercise, then there will be other cultural resources in their life that may be relevant.

### Pluralistic service delivery

The pluralistic framework for practice outlined by Cooper and McLeod (2011) is particularly appropriate in situations where one-to-one counselling is offered in the context of a 'frontline' counselling and psychotherapy service. In such a context, it is particularly important for the therapist to be able to use a flexible approach that is responsive to the many different ideas about help that are held by different clients, establish a collaborative relationship from the outset, and engage the active participation of the client.

Frontline therapy agencies need 'generalist' counsellors who are able to work with whoever walks through the door. In this case, a specialist therapist who had expertise in only one therapeutic model might be very effective with clients for whom that model made sense, but might struggle with clients who had other ideas about what would help them. In adopting a pluralistic perspective, it is important for organisations to be aware that pluralism is not merely a matter of employing counsellors who take a collaborative approach. Pluralism also involves consideration of diversity issues, practical aspects of a service such as flexibility in the length and timing of sessions, and being able to choose one's counsellor or change to another counsellor (Carey 2011, 2016).

That generalist counsellors are employed by community agencies and in primary healthcare does not reduce the need or demand for 'single-orientation' psychotherapists working in private practice or in secondary care. There are many people who make an informed choice that a specific approach to therapy (e.g. person-centred, CBT, psychodynamic) is right for them, and will seek out a therapist who can offer that way of working. Sometimes, it may be valuable for a generalist therapist to refer a client to a 'single-orientation' specialist colleague, if it turns out that client wishes to work more intensively within a particular change modality.

There are other models of service delivery that represent potentially valuable means of implementing a pluralistic approach. Some organisations, for example, offer a range of therapeutic experiences, including individual counselling, group therapy, weekend workshops, psycho-educational groups on topics such as anger management, mindfulness training courses, access to a library of 'therapeutic' DVDs and books, and so on. Some of these organisations also encompass complementary therapy practitioners. This format for service delivery allows the client to try out different therapeutic experiences, and different combinations of activities, in an environment in which each practitioner with whom they interact will have an appreciation of the nature of the other learning experiences that are on offer.

In recent years, many healthcare systems have started to use a 'stepped care' model to organise the delivery of counselling and psychotherapy (Chapter 31). Within this kind of structure, the client



is assessed and then (depending on the severity of the problem) referred to a low-intensity activity, such as supported reading or an online self-help package. If this first 'step' is not effective in addressing the problem, the client is then allocated to a higher intensity service, such as individual counselling or CBT. If this level of therapy is not effective, the client is referred again, perhaps to psychiatric care or to a specialist service that focuses on a particular disorder (e.g. eating disorders, alcohol dependency, bipolar disorder, etc.). It is important to note that while stepped care may be pluralistic from the point of view of the healthcare organisation, because from its perspective it is offering a range of therapies linked to patient/client need, it is not pluralistic from the point of view of the client. In stepped care systems the client has little choice, because what they receive is decided by the person who is assessing them. In principle, the array of services within a stepped care system could operate in a pluralistic fashion if, for example, information about all the possible therapies and therapists was made available on a website and the client was able to choose, and if there was open dialogue around the therapies that clients or user groups might wish to see included in the list.

## Training, supervision, and research

There are some key principles that can be used to guide and inform the design of pluralistic training programmes (Cooper and McLeod 2011; McLeod et al. 2016). In addition to coverage of topics such as professional issues and ethics, self-awareness, personal therapy/development, research skills, and the contribution of mainstream therapy approaches such as person-centred, CBT, psychodynamic, and narrative, the distinctive nature of the elements of a pluralistic approach to counselling and psychotherapy is highlighted by the following:

- attention to the philosophical rationale for pluralism;
- emphasis on training as a first step in lifelong learning;
- interpersonal skills and counselling skills training;
- theory and practice of metacommunication and collaborative case formulation;
- learning to use cultural resources;
- critically deconstructing different theoretical perspectives;
- training in the use of feedback tools to enable collaborative conversations with clients.

Similarly, while retaining the effective elements of other approaches, pluralistically oriented supervision has an additional focus on exploring how best to maximise the resourcefulness of both client and therapist. Being a pluralistic therapist involves a commitment to learning from clients and using self-practice and deliberate practice (see Chapter 28) to transform that learning into enhanced ways of working with clients.

Pluralistic therapy can be viewed as a way of combining ideas and methods from many approaches to therapy. Many of the elements of pluralistic therapy, such as the use of feedback and case formulation, are already supported by research. However, further research is required to explore and evaluate how these procedures operate in the context of a pluralistic framework, and the effectiveness of the framework as a whole for different client groups (Cooper et al. 2015).

## Conclusions

The pluralistic framework for practice outlined here has brought together key aspects of earlier approaches to therapy integration that were discussed in the previous chapter. It makes use of a strong meta-theoretical perspective – the philosophical concept of pluralism. It offers a strategy for drawing on therapy theory in ways that allow such ideas to have meaning and traction in the context

of the life of the client. The importance of common factors and the contextual model is reflected in the emphasis on interpersonal skills and counselling skills. The role of the therapist as a practitioner engaged in a continuing process of learning and development, highlighted in writing on the topic of assimilative integration, underpins the whole pluralistic approach. In many respects, pluralistic therapy can be viewed as a form of collaborative eclecticism. In addition, pluralistic therapy incorporates findings from current research into client preferences, working with goals, and the use of feedback. Over and above these integrative elements, pluralistic therapy invites a reconsideration of the relevance of the ethical and moral dimensions of therapy, and the everyday social context of the client (cultural resources).

There are substantial personal and organisational barriers to pluralism within the therapy professions. There are personal barriers that arise from the deep and genuine commitment and belief that many practitioners hold in relation to specific therapy models. This commitment and belief is not without foundation – over the years, an enormous amount of good has been done by practitioners of psychodynamic, person-centred, cognitive-behavioural, and other brand-name therapies, and innumerable productive and satisfying careers have been lived out within these arenas. There are also organisational barriers in the form of the investment required in training courses, journals, books, and bodies of research evidence that have been constructed around single models. Pluralism, as described in the present chapter, does not ask anyone to abandon ideas and methods that they already find useful. Pluralism merely invites serious consideration of other options, in addition to what is already familiar.

On the other hand, there are reasons to believe that we are experiencing a period of change in relation to the theory and practice of counselling and psychotherapy (Gergen 2000). There is a growing awareness that there are many different, effective ways of addressing anxiety, depression, relationship issues, and other presenting problems. There is also an appreciation that good therapy involves collaboration and dialogue between client and therapist, in a form that allows the strengths, resources, and knowledge of the client to be brought to bear on whatever it is that troubles them. One indicator of the current sea-change in counselling and psychotherapy is a shift in the image of the therapist. In most of the existing clinical literature and research, the therapist is the hero of the story. The therapist is the potent one whose ‘intervention’ makes a difference. In pluralistic stories, by contrast, the client is the hero. The client is the one who has the courage to face up to things, to draw on their own capacities, and to use whatever it is that their therapist has to offer.

A pluralistic approach to therapy represents a viable way for the therapy field as a whole to move forward, in terms of meeting emerging challenges (see Chapter 32). It opens up new possibilities in such areas as training, supervision, and research. It also creates possibilities for collaboration with practitioners and groups who have different skills and techniques, such as outdoor pursuits trainers, complementary therapists, poets, and artists.



## Topics for reflection and discussion

- 1 A pluralistic perspective suggests that there are multiple change processes that might be helpful to people who are struggling to cope with problems in living. To what extent is this position consistent with your own experience? Do you believe that there is a single, universal healing process that is of fundamental importance in therapeutic work?
- 2 What is your own personal preferred approach for dealing with challenges that emerge in your own life? Which therapy models are most, or least, compatible with your own problem-solving style? What might be the advantages and disadvantages of seeing a therapist who uses techniques and interventions that are significantly different from your existing personal coping strategies?

- 3 What are the cultural resources that have been most meaningful for you? In what ways have these resources enabled you to overcome personal difficulties such as periods of worry and low mood?
- 4 To what extent are you open and curious about the diversity of therapy theories and methods that are available? What form does this curiosity take (e.g. reading, talking with colleagues, attending training events)? What are the barriers that hold you back from learning more about different approaches? How might these barriers be overcome?
- 5 If you have had the experience of being a client in therapy, reflect on the degree to which your therapist(s) initiated or encouraged conversation around your ideas for how you could work most effectively together. Looking back, would it have been helpful to have had more conversation of this type, or not?

## Suggested further reading

Extended discussion of the ideas introduced in this chapter can be found in *Pluralistic Counselling and Psychotherapy* (Cooper and McLeod 2011), *Adolescent Counselling Psychology: Theory, Research and Practice* (Hanley et al. 2012), *The Handbook of Pluralistic Counselling and Psychotherapy* (Cooper and Dryden 2016), and *Pluralistic Therapy: Distinctive Features* (McLeod 2017a). One of the core assumptions of pluralistically oriented therapy is that the client is an active co-participant who has their own ideas about what will work. The concept of the 'active client' is explored in one of the classic therapy texts of recent years – *How Clients Make Therapy Work: The Process of Active Self-Healing*, by Art Bohart and Karen Tallman (1999). An inspiring portrayal of a master pluralist in action (although he does not describe his work in these terms) can be accessed in Bruce Levine's (2007) book on *Surviving America's Depression Epidemic: How to Find Morale, Energy, and Community in a World Gone Crazy*.



# PART

# 3

## Therapy as a response to cultural difference and social adversity

One of the central aspects of the common ground of therapy is the idea that individuals are *social beings*. It is not possible to grow up and become a person without continuous support and care from other people. Human survival, over millennia, has depended on effective collaboration between people, in the context of shared language and culture. Even the most biologically, ‘brain-savvy’ approaches to therapy do little more than identify the bodily structures that function as limiting factors in respect of interpersonal communication and connection.

In adopting theoretical models and research methodologies that reflect a primarily individualistic perspective, it could be argued that the world of counselling and psychotherapy has failed to pay sufficient attention to the social dimensions of practice. The chapters in this part of the book represent an attempt to offer a comprehensive introduction to a social perspective on therapy, grounded in an account of the ways in which its historical development has shaped the nature of current ideas and debates. There are separate chapters that examine the relevance for therapy of major dimensions of social life: culture, gender, and social class. The closing chapter in this section turns to questions around the broader social role of therapy, and explores a range of initiatives that have sought to develop forms of therapy that contribute to the furtherance of social justice.



# Chapter 22

## The historical context of contemporary practice

<b>Introduction</b>	<b>319</b>
<b>The social and historical origins of counselling and psychotherapy</b>	<b>320</b>
<b>The emergence of psychotherapy</b>	<b>321</b>
The establishment of psychiatry as a medical specialism	321
The earliest forms of psychotherapy: hypnosis and psychoanalysis	323
Therapy as a response to the loss of religious faith	325
Psychotherapy comes of age in the USA	325
The recent history of psychotherapy	328
<b>The emergence of counselling</b>	<b>330</b>
<b>The emergence of other professional identities</b>	<b>333</b>
<b>Towards a transcultural history of therapy</b>	<b>335</b>
<b>Conclusions</b>	<b>335</b>
<b>Topics for reflection and discussion</b>	<b>337</b>
<b>Suggested further reading</b>	<b>337</b>

### Introduction

People in all societies, at all times, experience emotional or psychological distress and behavioural problems. Each culture has its own, well-established indigenous ways of helping people to deal with these difficulties. In modern industrialised societies, in Europe, North America, Japan, New Zealand, and Australia, counselling and psychotherapy became established in the 1950s as credible and helpful ways through which people could address personal troubles and problems in living. Before that time, there were very few practitioners who described themselves as counsellors or psychotherapists – for most ordinary people, therapy was invisible, or was viewed as a curious activity undertaken only by those with leisure and privilege. Nevertheless, therapy gradually became more and more popular and widely available in these societies over the second half of the



twentieth century. It also became increasingly influential within other countries, giving it substantial global visibility and presence. Therapy has become one of the distinctive cultural features of our post-industrial world. How and why did this happen? Was it inevitable? What was happening in the twentieth century that served to propel therapy to the status of a major human service industry? What were the needs and problems to which therapy was a response? How had these needs and problems been dealt with before that time, and why were these previous solutions no longer appropriate?

The present chapter examines the nature of fundamental changes that occurred in Western society in the eighteenth century that laid the groundwork for the emergence of psychological approaches to understanding and resolving life challenges, which in turn led to counselling and psychotherapy and allied activities. The chapter also explores the ways in which counselling and psychotherapy have continued to be shaped by complex social, political, economic, and cultural factors, and the practical implications of a historical perspective on therapy.

The story of the emergence of therapy encapsulates key aspects of what it means to be a person in contemporary society. Therapy represents one of the places where the massive and all-pervasive tensions, fault lines, and cultural shifts that characterise modern life are negotiated at an individual level. Although in the therapy room we talk about our own life, our own personal struggles, a historical understanding makes it possible to see that at the same time we talk for all of us. Our ways of making sense of problems, and our strategies for resolving them, inevitably draw on cultural pathways that have been opened up by those who have gone before us. At the same time, therapy functions as a collective source of caring – a means through which society as a whole acknowledges and responds to trauma, loss, and other forms of adversity.

## The social and historical origins of counselling and psychotherapy

Prior to the eighteenth century in Europe, society was primarily based on small rural communities whose inhabitants lived according to religious principles. The Industrial Revolution brought about a fundamental shift, from traditional to modern ways of living and thinking. Increasingly, people moved to cities, worked in factories, and were influenced by scientific rather than religious belief systems. This shift was accompanied by major changes in the way that society responded to the needs of people who had problems in their lives. Before this, the problems in living that people encountered were primarily dealt with from a religious perspective, implemented at the level of the local community (Neugebauer 1978, 1979). Anyone who was seriously disturbed or insane was essentially tolerated as part of the community. Less extreme forms of emotional or interpersonal problems were dealt with by the local priest, for example through the Catholic confessional or 'cure of souls' (McNeill 1951). An important element of the 'cure of souls' was confession of sins followed by repentance. In earlier times, confession of sins took place in public, and was often accompanied by communal admonishment, prayer, and even excommunication (Richardson and Stewart 2009). The original Christian rituals for helping troubled souls were, in similar fashion to healing rituals in non-Christian cultures, largely communal affairs. Only later did individual private confession become established.

As writers such as Foucault (1967), Rothman (1971), Scull (2015), and Porter (1985) have pointed out, all this began to change as the Industrial Revolution took effect, capitalism began to dominate economic and political life, and the values of science began to replace those of religion. The fundamental changes in social structure and in social and economic life that took place at this point in history were accompanied by basic changes in relationships and in the ways people defined and dealt with emotional and psychological needs. Modern capitalist societies required a workforce that exhibited a rational, goal-oriented, and disciplined approach to work, which in turn required control

and suppression of spontaneity, pleasure-seeking, and sexuality (Albee 1977). A key psychological shift took place, from a 'tradition-centred' society to one in which 'inner direction' was necessary for success (Riesman et al. 1950)

In traditional cultures, people live in relatively small communities in which everyone knows everyone else, and behaviour is monitored and controlled by others. There is direct observation of what people do, and direct action taken to deal with social deviance through scorn or exclusion. By contrast, in modern urban, industrial societies, life is much more anonymous, and social control must be implemented through internalised norms and regulations, which result in shame if they are defied. In an important sense, the psychology of being a person, and the sense that people had of who they were and how they related to others, were gradually transformed as a result of the Industrial Revolution and its impact on all aspects of social life.

At the same time, there was a fundamental transformation of the structure of the workplace, the kinds of jobs that were available to people, and the type of education that was required in order to undertake these roles. Before the eighteenth century, there was a limited range of occupations, and access to them was largely determined based on social class, religion, and geographical location. As industrialisation and urbanisation rolled out across Europe and North America, a vast range of new work roles were created. In the new industrial and commercial enterprises that took shape, it was no longer possible to select job candidates on the basis of personal acquaintance. In addition, more and more jobs required specialist training. The few universities that existed in the earlier era were dedicated in the main to producing physicians, clergy, and lawyers. Now, people were staying at school longer (leading to a new perception of the meaning of 'childhood') and more people were attending colleges and universities.

The sociologist Anthony Giddens (1991) has argued that the emergence of the new 'modern' world created massive dilemmas for people in terms of planning the course of their lives. No longer was a personal future mapped out for a person by their family and community. Within just one or two generations, a vast array of personal choices came into being, in respect of the capacity – and pressure – to construct a personal identity and career trajectory. Inevitably, these choices were associated with a growth in anxiety ('am I making the right decision?', 'can I cope with this role?') and depression ('I have failed', 'I am not achieving as much as other people').

The conditions of urban, industrial, capitalist culture created a need for new sources of help, guidance, and support that addressed the confusions and dilemmas experienced by individuals. What then happened was the development of psychological (rather than faith-based or philosophical) ways of making sense of self, which in turn led to the emergence of practices that came to be described as 'counselling' or 'psychotherapy'. How all this happened is a complex story. Basically, one form of personal support, which became 'psychotherapy', emerged within and out of the world of medicine. A similar form of helping practice, which became known as 'counselling', emerged from non-medical spheres such as education and social work. Variants of these practices, such as career counselling, coaching, and embedded counselling, became established within specific arenas of social life.

## The emergence of psychotherapy

The origins of psychotherapy can be traced back to developments in society, and then within the field of medicine in the eighteenth and nineteenth centuries.

## The establishment of psychiatry as a medical specialism

During the years 1800–1890, the proportion of the population of England and Wales living in towns larger than 20,000 inhabitants increased from 17 to 54 per cent (Scull 2015). People were leaving the land and heading to the towns and cities to work in the new factories. Even on the land, the work

became more mechanised and profit-oriented. These large-scale economic and social changes had profound implications for all disadvantaged or handicapped members of society. Previously there had been the slow pace of rural life, family members on hand working at home, and tasks that could be performed by even the least able. Now there was the discipline of the machine, long hours working in the factory, and fragmentation of communities and family networks that previously had taken care of the old, sick, poor, and insane. Very quickly, out of necessity, a new system of state provision for these non-productive members of the population was introduced – the workhouse. Inmates of workhouses were made to work under conditions of strict discipline.

Gradually, it became apparent that it was more efficient, within the workhouse system, to establish ‘separate apartments’, or asylums, specifically for the care of the insane. In Britain and other European countries, this began slowly in the middle of the eighteenth century and was given further encouragement in Britain by the 1845 Asylums Act, which compelled local justices to set up publicly run asylums.

The development of ‘asylums’ marked the first systematic involvement of the state in the care and control of the insane in European society. At first, the asylums were seen as places where lunatics could be contained, and any attempt at therapeutic intervention was rare. In a few asylums run by Quakers – for example, Tuke at the York Asylums – there evolved what was known as ‘moral treatment’ (Borthwick et al. 2001; Scull 2015). In most institutions, however, lunatics were treated like animals and kept in appalling conditions. The Bethlem Hospital in London, for instance, was open to the public, who could enter to watch the lunatics for a penny a time. During this early period of the growth of the asylums movement, at the beginning of the nineteenth century, the medical profession showed little interest in the insane. However, the medical profession gradually came to recognise that there were profits to be made from the ‘trade in lunacy’, not only from having control of the state asylums, which were publicly funded, but also from running asylums for the insane members of the upper classes (Scull 2015). The political power of the medical profession allowed them, in Britain, to influence the contents of Acts of Parliament that established medical control over asylums. The defeat of moral treatment can be seen as a key moment in the history of psychotherapy: science replaced religion as the dominant ideology underlying the treatment of the insane.

During the remainder of the nineteenth century, the medical profession consolidated its control over the ‘trade in lunacy’. Part of this process of consolidation involved rewriting the history of madness. Religious forms of care of the insane were characterised as ‘demonology’, and the persecution of witches was portrayed, erroneously, as a major strand in the pre-scientific or pre-medical approach to madness (Kirsch 1978; Spanos 1978; Szasz 1971). Medical and biological explanations for insanity were formulated, such as phrenology (Cooter 1981) and theories of sexual indulgence or masturbation (Hare 1962). Different types of physical treatment were experimented with, such as hypodermic injections of morphine, the administration of bromides, amyl nitrate, the application of electricity, and the use of Turkish baths. An important theme throughout this era was the use of the asylum to oppress women, who constituted the majority of inmates (Appignanesi 2008; Showalter 1985). Towards the end of the century, the medical specialism of psychiatry had taken its place alongside other areas of medicine, backed by the system of classification of psychiatric disorders devised by Kraepelin, Bleuler, and others. Many of these developments were controversial at the time. For example, there was considerable debate over the wisdom of locking up lunatics in institutions, since contact with other disturbed people was unlikely to aid their rehabilitation. Several critics of psychiatry during the nineteenth century argued that care in the community was much better than institutionalisation. There was also a certain amount of public outcry over the cruelty with which inmates were treated, and scepticism over the efficacy of medical approaches.

The issues and debates around the care of the insane in the nineteenth century seem very familiar, since we are still arguing about the same things more than a century later. But an appreciation of how these issues originally came into being can help us by bringing into focus a number of very clear conclusions about the nature of care offered to emotionally troubled people in modern

industrial society. When we look at the birth of the psychiatric profession, and compare it with what was happening before the beginning of the nineteenth century, we can see that:

- emotional and behavioural ‘problems in living’ became medicalised, and subsumed into diagnostic categories;
- there was a shift from informal to state-controlled forms of care;
- a ‘trade in lunacy’ emerged through an involvement of market forces in the development of services;
- there was increased rejection and cruelty, and negative attitudes, relating to the way that the insane were treated, as well as much greater social control;
- the services that were available were controlled by men and used to oppress women; and
- science replaced religion as the main framework for understanding madness.

None of these factors was evident to any extent before the Industrial Revolution and all are still with us today. They can be seen as fundamental to the way that any industrialised, urbanised, secularised society responds to the question of madness. The French social philosopher Michel Foucault (1967) pointed out that one of the central values of the new social order that emerged in the nineteenth century was reason or rationality. For a society in which a rational, scientific perspective on life was all-important, the irrational lunatic, who had lost their reason, would readily become a scapegoat, a source of threat to be banished to an asylum somewhere outside the city. Foucault (1967) describes this era as an ‘age of confinement’, in which society developed means of repressing or imprisoning representatives of unreason or sexuality.

## The earliest forms of psychotherapy: hypnosis and psychoanalysis

By the end of the nineteenth century, psychiatry had achieved a dominant position in the care of the insane, now re-categorised as ‘mentally ill’. From within medicine and psychiatry, there now evolved a new specialism of psychotherapy. The earliest physicians to call themselves psychotherapists were Albert van Renterghem and Frederik van Eeden, who opened a clinic of suggestive psychotherapy in Amsterdam in 1887 (Ellenberger 1970). Van Eeden defined psychotherapy as a ‘curative method’ that used ‘psychic agents’ to combat illness (Shamdasani 2005).

The specific psychical agent that turned out to be of crucial value was hypnosis – a phenomenon of great interest to the European medical profession in the nineteenth century. Originally discovered by the pioneers of ‘animal magnetism’, Johann Joseph Gassner (1727–79) and Franz Anton Mesmer (1734–1815), hypnotism came to be widely used as an anaesthetic in surgical operations before the invention of chemical anaesthetics. During the 1880s, the influential French psychiatrists Jean-Martin Charcot and Pierre Janet began to experiment with hypnosis as a means of treating ‘hysterical’ patients. There were two aspects of their hypnotic technique that have persisted to this day as key concepts in contemporary counselling and psychotherapy. First, they emphasised the importance of the relationship between doctor and patient. They knew that hypnosis would not be effective in the absence of what they called ‘rapport’. Second, they argued that the reason why hypnosis was helpful to patients was that it provided access to an area of the mind that was not accessible during normal waking consciousness.

The part played by hypnosis in the emergence of Western psychotherapy is hugely significant. Bourguignon (1979), Prince (1980), and many others have observed that primitive cultures employ healing rituals that rely on trance states or altered states of consciousness. The appearance of mesmerism and hypnosis through the eighteenth and nineteenth centuries in Europe, and their transformation into psychotherapy, can be viewed as representing the assimilation of an ancient cultural practice into modern scientific medicine.

The key figure in the transition from hypnosis to psychotherapy was Sigmund Freud. Having spent four months with Charcot in Paris during 1886–87, Freud went back to Vienna to set up in

private practice as a psychiatrist. He soon turned his back on the specific techniques of hypnosis, choosing instead to develop his own method of psychoanalysis based on free association and the interpretation of dreams. Freud became, eventually, an enormously powerful figure not only in medicine and psychotherapy, but in European cultural history as a whole. Without denying the genius and creativity of Freud, it is valuable to reflect on some of the ways in which his approach reflected the intellectual fashions and social practices of his time. For example:

- Individual sessions with an analyst were an extension of the normal practice of one-to-one doctor–patient consultations prevalent at that time.
- Freud's idea of a unitary life-force (libido) was derived from nineteenth-century biological theories.
- The idea that emotional problems had a sexual cause was widely accepted in the nineteenth century.
- The concept of the unconscious mind had been employed not only by the hypnotists, but also by other nineteenth-century writers and philosophers.

The distinctive contribution of Freud was his capacity to assimilate all of these ideas into a coherent theoretical model, and then to actively and effectively disseminate his ideas.

The cultural significance of Freudian ideas can be seen to lie in the implicit assumption that we are all neurotic, that behind the façade of even the most apparently rational and successful person there lie inner conflicts and instinctual drives. The message of Freud was that psychiatry is relevant not just for the mad man or woman in the asylum, but for everyone. The set of ideas contained in psychoanalysis also reflected the challenges faced by members of the European middle classes making the transition from traditional to modern forms of relationship. For example, Sollod (1982) observed that while Victorian society advocated unquestioning respect towards elders and employers as father-figures, the kind of impersonal economic and employment arrangements that prevailed in modern life meant that deferential relationships to authority figures could be inappropriate and maladaptive rather than functional.

Freudian ideas had a somewhat limited impact in Britain and Europe during his lifetime. Until the latter half of the twentieth century, psychoanalysis was accessible only to middle-class intellectuals and artists. In Britain, for example, the early development of psychoanalysis was associated with the literary elite of the 'Bloomsbury group' (Kohon 1986).

### **Box 22.1: Critical perspectives on the role of counselling and psychotherapy in contemporary society**

A central theme in this chapter is the idea that counselling and psychotherapy can be viewed as necessary and valuable strategies for coping with the impact of personal and family life of modern industrialised, bureaucratised, and capitalist forms of social organisation. However, there are also several writers who have argued that therapy represents a false and destructive response to these pressures. Furedi (2004), Madsen (2014), Morrall (2008), Smail (1991, 2001, 2005), and others have drawn attention to the overblown personal transformation and cure claims made by some therapists, and the proliferation of psychiatric jargon and diagnostic categories in everyday conversation. These critics argue that the spread of 'therapy culture' has led to an individualisation of problems that has made it harder for people to identify – and tackle – the social factors that lie behind these issues. Other critics, such as Masson (1992) and the contributors to the volume edited by Bates (2006), argue that the apparently benign image of therapy conceals a significant amount of exploitative and damaging practice, arising from the power imbalance between therapists and their clients.



## Therapy as a response to the loss of religious faith

Underpinning all of the historical processes discussed in earlier sections of this chapter was a gradual shift away from organised religion, in the direction of a society organised around secular, scientific beliefs. Halmos (1965) documented the correspondence in the twentieth century in Britain between the decline in numbers of clerical personnel and the rise in numbers of therapists, and argued that religious faith was gradually replaced by a set of beliefs and values that he calls the 'faith of the counsellors'. Nelson and Torrey (1973) described some of the ways in which therapy has taken over from religion in such areas of life as offering explanations for events that are difficult to understand, offering answers to the existential question 'what am I here for?', defining social values, and supplying ritual ways of meeting other people. Holifield (1983) noted that some of the first 'psychotherapists' were part of the church in the USA before gradually transforming into a separate profession. Myers-Shirk (2000) has discussed the role of the Protestant churches in the USA in disseminating counselling approaches in the 1920s and 1930s, in the form of pastoral care.

To be able to locate itself as a product in the twentieth-century marketplace, and create a mental health 'industry' (Kovel 1981), therapy differentiated itself from religion. In general, mainstream theories of counselling and psychotherapy have had little to say about religious or spiritual dimensions of life. Therapy is embedded in a scientific worldview, even if, as Halmos (1965) has argued, theories of therapy can be seen as a form of 'faith'.

A valuable contribution to understanding the interface between psychotherapy and religion has been made by the historian Gavin Miller, who analysed the relationship between the established Protestant religious tradition in Scotland and the development of psychotherapy in that country (G. Miller 2007, 2008, 2009, 2015, 2018). This programme of research has shown that the Scottish tradition in psychotherapy, expressed in the work of key figures such as Fairbairn, Rushforth, and Laing, incorporates indigenous religious themes and forms of argument, and can be viewed not as a replacement of fundamental cultural values and practices, but as a gradual process of re-shaping them.

## Psychotherapy comes of age in the USA

It was not until psychoanalysis was transported to the USA that psychotherapy became more widely available to the general public. Underlying cultural factors in American culture and society in the nineteenth and twentieth centuries represented ideal conditions for the expansion of psychotherapy (Cushman, 1990, 1992, 1995). America was a new nation in which in the nineteenth century people were subjected to massive social change and transformation. The early precursors of psychotherapy in the USA, such as mesmerism or the revivalist movement, were attempts to find meaning and stability at a time of enormous social uncertainty. At the same time, the capitalist system, much more dominant in America than in European countries, demanded that individuals mould themselves to the requirements of particular niches in the economic system. People had to learn how to sell not only goods and services, but themselves. Self-improvement books and pamphlets were very popular, but psychotherapy offered a more effective way of achieving the right kind of personality.

The extent of social mobility in America meant that traditional social structures, such as family and community, became eroded and the sense of purpose and belonging associated with these structures was lost, with the result that a core experience of many Americans, Cushman (1990) has argued, has been that of a sense of an 'empty self'. The two major cultural responses to the empty self, according to Cushman (1990), have been psychotherapy and consumerism/advertising. In order to assuage 'undifferentiated emotional hunger', the citizen of an advanced capitalist economy has the choice of making an appointment with a therapist or, perhaps, buying a new car. The link between the emergence of psychotherapy in twentieth-century America and the development of a consumer society has been discussed by other historical writers, such as Caplan (1998) and Pfister (1997). A key theme in these historical accounts has been the extent to which psychotherapy approaches have consistently diverted attention from the social conditions that trigger personal



problems in living, by promising solutions to these problems that are based on the identification of dysfunctional aspects of the individual psyche. The result of this movement in the direction of self-contained individualism is argued, by these authors, to erode the basis of social solidarity and cultural capital that might in fact make it possible for people to mount a collective response to the demands of capitalist economic forces.

An essential catalyst that captured the imagination of Americans and paved the way for the growth of psychotherapy in the USA was the visit of Sigmund Freud in 1909. Freud had a great loathing of American society. He did not enjoy his one and only trip to the USA, with Carl Jung and Sandor Ferenczi, to give some lectures and receive an honorary degree at Clark University (Gay 1988). But American culture resonated to the ideas of psychoanalysis, and when the rise of fascism in Europe led to prominent analysts like Otto Rank and Erik Erikson moving to New York and Boston, they found a willing clientele. Psychoanalytic ideas also had a significant impact on popular debates around the nature of family life, parenting, and child-rearing.

The idea of psychoanalysis held a great attraction for Americans, but for it to become assimilated into the culture required an Americanisation of Freud's thinking. Freud had lived in a hierarchically organised, class-dominated society, and had written from a worldview immersed in classical scholarship and biological science, informed by a pessimism arising from being a Jew at a time of violent anti-Semitism. There were, therefore, themes in his writing that did not sit well with the experience of the American people. As a result, in the 1950s a series of writers re-interpreted Freud in terms of their own cultural values. Foremost among these were Carl Rogers, Eric Berne, Albert Ellis, Aaron Beck, and Abraham Maslow. Many of the European analysts who went to the USA, such as Erikson and Erich Fromm, were also prominent in reframing psychoanalysis from a wider social and cultural perspective, thus making it more acceptable to an American clientele.

One of the strongest sources of resistance to psychoanalysis in American culture lay in academic psychology. Although William James (1890), who had been one of the first scholars to make psychology academically respectable in American universities, had given close attention to Freudian ideas, in the first half of the twentieth century American academic psychologists had become deeply committed to a behaviourist approach. Behaviourism emphasised the use of scientific methods such as measurement and laboratory experiments, and was primarily oriented to the study of observable behaviour rather than obscure internal processes, such as dreams, fantasies, and impulses. The behaviourist academic establishment was consequently fiercely opposed to psychoanalysis, and refused to acknowledge it as worthy of serious study. Although some academic departments of psychiatry did show some limited interest in psychoanalysis, most practitioners and writers were forced to work in private practice or within the hospital system, rather than having an academic base.

When Rogers, Berne, and Ellis developed distinctive American brands of therapy in the 1950s and 1960s, there was initially only very limited academic discussion of their work and ideas. One of the distinctive contributions of Rogers was to invent systematic methods of carrying out research into the processes and outcomes of therapy. The effect of this innovation was to reinforce the legitimacy of therapy as a socially acceptable enterprise by giving it the respectability and status of an applied science. In 1947, Rogers became the first therapist to be made President of the American Psychological Association (Whiteley 1984). The confirmation of therapy as an applied science was given further impetus by the entry into the therapy arena of cognitive-behavioural approaches in the 1960s, bringing with them the language and assumptions of behavioural psychology and the image of the 'scientist-practitioner'.

One impact of the Second World War on the USA was the substantial number of soldiers returning home with psychological injuries, particularly from the Pacific theatre. In turn, this led to pressure from the Veterans' Administration, the government organisation responsible for the health and social welfare of former service personnel, and from society more widely, for some kind of psychotherapy to be made available. The client-centred therapy of Carl Rogers represented the most credible contender for a form of psychotherapy that was relatively brief and affordable, and for which new

therapists could be trained fairly rapidly. The consequence was that there was major investment in client-centred therapy in the late 1940s, which meant that, for a time in the 1950s, it became the dominant therapeutic approach in the USA and then worldwide (Barrett-Lennard 1998; Kirschenbaum 2007). Client-centred therapy was similar to psychoanalysis in that it was built around an exploration of self, or a search for a 'real' self, but was less time-consuming, more egalitarian in its philosophy, and more optimistic. Whereas psychoanalysis was well suited to the emotional needs of the European middle classes, client-centred therapy was better attuned to the lives and aspirations of those in the USA.

### Box 22.2: The pivotal role of Carl Rogers

Carl Rogers was a key figure in the development of counselling and psychotherapy. The life of Carl Rogers (1902–1987), founder of the client-centred or person-centred approach to therapy, reflects many of the cultural themes underpinning the development of therapy in the twentieth century (Kirschenbaum 1979, 2007). Rogers was brought up in a rural community in the American Midwest, a member of a strictly religious Protestant family in which there was active disapproval of leisure activities such as gambling and theatre-going. As a substitute for forbidden leisure pursuits, Rogers displayed a strong interest in scientific agriculture, by the age of 14 conducting his own experiments on crops and plants. He decided to become a minister and, at the age of 20, in preparation for this vocation was a delegate to the World Student Christian Federation Conference in China. This exposure to other cultures and beliefs influenced him to break away from the rigid religious orientation of his parents, and when he entered theological college he chose one of the most liberal seminaries, the Union Theological Seminary. However, following exploration of his faith in the equivalent of a student-led 'encounter group', Rogers decided to change career and began training as a psychologist at Columbia University, where he was exposed to the ideas of the progressive education movement, which emphasised a trust in the freedom to learn and grow inherent in each child or student.

Rogers' early life shows how the dual influences of religion and science came together in a career as a therapist. The respect for scientific rigour was expressed in his involvement in research. He was one of the first to make recordings of therapy sessions, and developed a wide range of methods to investigate aspects of the therapy process. The influence of Protestant thought on client-centred theory is apparent in the emphasis on the capacity of each individual to arrive at a personal understanding of their destiny. Rogers was, in his clinical work, and earlier in his experience at Columbia, immersed in the values of American culture, and his theory contains many elements of that cultural context. Meadow (1964), for example, has suggested that client-centred therapy has adopted 'basic American cultural norms', such as distrust of experts and authority figures, an emphasis on method rather than theory, an emphasis on individuals' needs rather than shared social goals, a lack of interest in the past, and a valuing of independence and autonomy. Barrett-Lennard (1998) has drawn attention to the similarities between Rogers' approach and the philosophy of the 'New Deal' political movement in the USA in the 1930s.

It is possible to see, therefore, that there were many factors that contributed to the rapid growth of psychotherapy in American society in the middle of the twentieth century. Because of the global influence of the USA in the post-war years, this had the effect of triggering an expansion of psychotherapy in other countries too. The particular cultural circumstances that prevailed in mid-twentieth-century America had a big impact on the shape of psychotherapy practice, which has persisted to this day. The relative weakness of state-funded healthcare in the USA meant that psychotherapy largely took

the form of a private practice model, rather than a more community-based approach. The competitive capitalist ethos there also meant that innovative therapists were rewarded for producing new 'brand-name' therapies, rather than for contributing to a more collective pooling of wisdom – thus contributing to a proliferation in therapy approaches and theories. And the growth of psychology, as an emergent academic discipline, meant that the legitimacy of psychotherapy became increasingly dependent on its capacity to undergo the trial of rigorous objective research.

## The recent history of psychotherapy

Since it first emerged, psychotherapy has undergone a continuous process of adaptation and reconstruction in response to social, political, and technological change. Some of the key shifts in emphasis that have occurred include the assimilation of ideas and practices from non-Western cultural traditions, the impact of neoliberal economic policies, the growing influence of research findings, and the increasingly technologised nature of much contemporary practice.

At a global level, in many countries, significant aspects of social and cultural life have been dominated by the 'soft power' of North American and European ideas and cultural values, as well as by the economic hard power of their industry, commerce, and investment. In the field of counselling and psychotherapy, indigenous forms of healing within many communities have been suppressed or denigrated in favour of Western psychiatric and psychotherapeutic models of intervention. However, this is a field that has always been characterised by two-way traffic. Carl Jung, second-generation psychoanalysts such as Erich Fromm, and many leading figures in humanistic psychology and therapy, were interested in concepts and techniques from Eastern mysticism, Buddhism, yoga, and native North American healing systems, and sought to integrate these influences into their practice. More recently, mindfulness theory and practice have played an increasingly significant role in cognitive-behavioural therapy. At a broader level, there has been an acknowledgement that the highly secular rejection of religion that was associated with the early pioneers of therapy, has resulted in insufficient attention being paid to aspects of life that represent core sources of meaning for many people. As a consequence, within psychotherapy there has been gradual movement in the direction of engaging with questions of spirituality and religious faith.

A significant shift has occurred within psychotherapy in relation to the type of knowledge that is used to inform practice. The pioneers of psychotherapy, such as Freud and Jung, relied on clinical evidence, derived from their experience of working with clients, and disseminated through clinical case studies. The development, within psychology, of a wide range of rigorous research methodologies has made it possible to evaluate and observe the process and outcomes of psychotherapy in a more systematic fashion. The availability of reliable research evidence has allowed service providers, such as governments and insurance companies, as well as therapy trainers and practitioners, to make increasing use of research evidence based on randomised clinical trials as the 'gold standard' of evidence that can guide practice (Rosner 2018). This has resulted in a gradual movement towards favouring therapy interventions that can be more readily studied (e.g. brief therapy and cognitive techniques) and a corresponding discounting of personal, experiential, and holistic forms of knowing.

Psychotherapy practice and research has always been strongly influenced by the political context in which it has operated. In the decades immediately following the Second World War, European societies – and to some extent that of the USA – were organised around an ideology of democratic social welfare capitalism. This was a period of economic expansion and prosperity, which made it possible to offer more generous welfare and healthcare policies, along with improved rights for women, members of ethnic minority groups, disabled people, and workers in general. During this period, the share of national wealth that accrued to ordinary people gradually increased, while the share that was in the hands of the wealthiest 10 per cent of the population gradually diminished (Piketty 2014). During the 1970s, *neoliberalism* began to emerge as the dominant political ideology within industrialised societies. Neoliberalism is the belief that society functions most

effectively when it operates on the basis of open markets. As Harvey (2007) and many other political analysts have pointed out, although the call for open competition may seem like a good idea, in reality neoliberal political and economic policies reflected a deliberate and planned move on the part of the wealthy to restore their share of national resources. Communally owned resources, such as healthcare systems, were 'privatised', thus transferring wealth from ordinary citizens to wealthy individuals who could afford to 'invest' in such enterprises. Changes to the taxation system meant that rich people paid proportionately less tax, while poorer people paid proportionately more. The increasing globalisation of economic activity meant that it became increasingly easy to move capital and jobs to wherever wage rates and taxes were lowest.

The shift to neoliberalism has had a major impact on the kind of therapy that is provided, particularly the kind of therapy that is available through state-funded or insurance-reimbursed services. In the early period of democratic social welfare capitalism, therapy theory and practice, in the form of psychoanalytic and humanistic approaches, emphasised themes such as self-awareness, self-understanding, and personal growth. By contrast, therapy in the more recent neoliberal era has become shorter, therapists are treated as technicians rather than autonomous professionals, and therapy is increasingly regulated within some kind of 'managed care' system. The underlying theme is that therapy is not a means of facilitating personal growth and a capacity to live a full life, but instead is a means of patching people up so they are fit for work. Many within the psychotherapy profession have been highly critical of what they regard as a significant shift away from professional autonomy and an ethical 'client-centred' approach towards a style of therapy that could be described as the application of *psychotechnology*. Increasingly, clinicians are required to use specific techniques and measures guided by a treatment manual rather than pursuing a way of working that prioritises the development of a healing relationship (Cushman and Gilford 1999) that draws on the full range of personal experience and professional knowledge available to the therapist. In Britain, this kind of shift has taken place under the auspices of the Improving Access to Psychological Therapies (IAPT) programme (Clark 2011; Rizq 2012).

Neoliberalism also introduces a particular standpoint or way of thinking about problems. The central assumption of neoliberal thinking is that competition and open markets make it possible for talent and ingenuity to prosper, through the creation of goods and services that people want to buy. Within a neoliberal system, the accumulation of wealth is highly valued, because it reflects productive market outcomes. Poverty is regarded as the responsibility of the person who is poor, who is viewed as not working hard enough to make a decent living. From this kind of perspective, the focus of therapy becomes more and more oriented towards the individual, and in particular the capacity of the individual to make the most of their biological/genetic potential, rather than on solidarity with others. The outcomes of therapy increasingly came to be defined in terms of symptom reduction, which can be understood as reflecting fitness to work. These are some of the ways in which contemporary psychotherapy practice can be regarded as influenced, at a deep level, by neoliberal thinking. In response to this kind of political environment, some therapists have sought to fight back by advocating a social justice agenda for therapy, or developing explicitly collectivist therapy approaches.

The process of reshaping therapy in response to social change continues. Recent significant sources of influence on therapy theory and practice have been global warming/environmental sustainability and technology. The effects of global warming represent one of the main dangers faced by the human race as a whole. Over the last two decades, this issue has stimulated the development of therapy approaches such as eco-therapy, nature therapy, and walk and talk therapy. These forms of therapy are largely conducted out of doors with the aim of enabling an embodied awareness of the fundamental links between the natural world and individual well-being. The growth of technology, and ways in which it has permeated all aspects of everyday life, has also had a growing impact on therapy practice. Social media, smart phones, and virtual reality systems open up new ways for therapists to communicate with clients and set up types of learning experience that are not possible in traditional face-to-face interaction during a weekly one-hour therapy session. Technology also has

an impact on the sense of self of members of contemporary society. For example, there is evidence that younger people who have grown up with smart phones and computer games exhibit a different type of cognitive functioning. Sense of self can also be affected by biomedical interventions, such as assisted conception technology, transplant, gender reassignment, and neural enhancement.

There are a number of areas in which contemporary social change is beginning to lead to shifts in therapy practice. The nature of the professional role is in a process of transformation. As a result of information available on the internet, members of the public are better informed about the tasks undertaken by professionals and have greater access to professional knowledge. There is also a greater sense of entitlement to professional services and a growing desire for a more equal or collaborative relationship with professional experts who are being consulted. Taken together, these factors have generated, at both a healthcare policy and front-line practice level, an emphasis on shared decision-making, service user involvement, user feedback, and outcome monitoring. A further dimension of social change that is gradually having an impact on therapy has been a refugee crisis that has resulted in many thousands of emotionally traumatised people being relocated in Canada and in many European countries, or held in camps. The presence of these people has had the immediate effect of prioritising research and practice development around the provision of culturally sensitive therapies. Additional issues are the reactions of the host population to refugees, or to the denial of entry to refugees.

### Box 22.3: Popular interest in psychology – Pelmanism

The social and cultural changes that had occurred in industrialised nations resulted in a massive popular interest in the early twentieth century around how to cope with the demands and stresses of everyday life. This interest pre-dated the establishment of academic psychology as a significant force in the university sector, or the widespread availability of counselling and psychotherapy. In Britain and many other countries, Pelmanism represented one of the most influential and widely used manifestations of this movement (Thomson 2007). Pelmanism (not to be confused with the card game of the same name) comprised a structured system for training the mind to think logically and effectively, coupled with guidance around relationships, emotional life, physical fitness, and diet. Between 1910 and 1967, more than half a million people subscribed to a Pelmanism course consisting of 15 booklets supported by written correspondence with a teacher. Pelmanism was endorsed by many leading figures of the time, and a special version of the training was prepared for British military personnel in the Second World War. From a contemporary perspective, the activities and exercises used in Pelmanism are similar to mindfulness and CBT interventions. The existence of Pelmanism, and other similar systems, supports the idea that, rather than psychotherapeutic models being developed by psychologists and other professional experts and then disseminated to the public, there exists a substantial reservoir of common-sense and everyday shared cultural knowledge within which all, or most, formal theories of therapy are grounded (Mahrer 2007a; Postle 2012).

## The emergence of counselling

The history of psychotherapy has been much more fully documented than has the history of counselling. Counselling, as a distinct profession, came of age only in the 1940s. One of the public markers of the emergence of counselling at that time was that Carl Rogers, in the face of opposition from the medical profession to the idea that anyone without medical training could call himself a 'psychotherapist', began to use the term 'counselling and psychotherapy' to describe his approach (Rogers 1942). Although in many respects counselling, both then and now, can be



seen as an extension of psychotherapy, a parallel activity, or even a means of 'marketing' psychotherapy to new groups of consumers, there are also at least two important historical strands that differentiate counselling from psychotherapy: involvement in the educational system and the role of the voluntary sector. The American Personnel and Guidance Association (APGA), which was later to become the American Counseling Association, was formed in 1952 through the merger of a number of vocational guidance professional groupings that were already well established by that time. The membership of the APGA consisted of counsellors who worked in schools, colleges, and career advisory services. In Britain, the Standing Council for the Advancement of Counselling, which was later to become the British Association for Counselling, was inaugurated in 1971 by a network of people who were primarily based in social services, social work, and the voluntary sector.

The precursors to the formation of these organisations can be understood in terms of a sense of crisis within society, or 'moral panic', around various areas of social life. In effect, what happened was that there was a sense of unease around some aspect of the breakdown of social order, or the identification of groups of individuals who were being unfairly treated in some way. These crises were characterised by widespread publicity about the problem, debate in newspapers and magazines, and efforts to bring about political or legislative change. At some point in this process, someone would have the idea that the best means of helping was to treat each person who needed assistance as an individual, and that the most effective way to proceed was to sit down with that individual, discuss the matter, and find the best way forward for that person in terms of their unique needs and circumstances. The idea of 'counselling' appears to have emerged more or less simultaneously, in many different fields of social action, in this manner.

Probably the first recorded example of this kind of 'invention of counselling' was in the work of the American social reformer Frank Parsons (1854–1908). Parsons had been employed as an engineer, lawyer, and writer before turning to lecturing, at Boston University. He was well known, internationally, for his writing and lecturing in which he argued against the uncontrolled capitalism of the time, and proposed that it should be replaced by a philosophy of *mutualism* – 'the replacement of competition by cooperation, and lust for money by concern for humanity' (Gummere 1988: 403). He campaigned for votes for women and public ownership of key industries. In the final years of his life, Parsons came to be particularly interested in the issue of helping young people to be matched with jobs that were right for them. He established a 'Vocation Bureau' in an immigrant district of Boston, where young people were interviewed and assessed, provided with information about possible career choices, and provided with opportunities to explore their feelings around the work they would like to do. The philosophy of the Bureau was clearly grounded in what we now consider to be a counselling approach (Parsons 1909). The Vocation Bureau operated as an example and catalyst for the expansion of counselling provision in schools and vocational guidance services throughout the USA (O'Brien 2001). Counselling of various kinds came to be offered within the school and college systems in the 1920s and 1930s, as careers guidance and also as a service for young people who were having difficulties adjusting to the demands of school or college life. Psychological testing and assessment were bound up with these activities, but there was always an element of discussion or interpretation of the student's problems or test results (Whiteley 1984).

In Britain, counselling had strong roots in the voluntary sector. For example, the largest single counselling agency in Britain, the National Marriage Guidance Council (now RELATE), dates back to 1938, when a clergyman, Dr. Herbert Gray, mobilised the efforts of people who were concerned about the threat to marriage caused by modern life (Tyndall 1985). The additional threat to married life as a result of the Second World War led to the formal establishment of the Marriage Guidance Council in 1942. A comprehensive historical analysis of the growth of the National Marriage Guidance Council, in response to societal and governmental alarm about divorce rates and marital breakdown, has been published by Lewis et al. (1992). Since that time, many other groups of volunteers have set up counselling services as a response to perceived social breakdown and crisis in areas such as rape, bereavement, gay and lesbian issues, and child abuse. As with the National



Marriage Guidance Council, many of these initiatives were led by church groups. For example, in Scotland, many counselling agencies owe their existence to the pioneering work of the Board of Social Responsibility of the Church of Scotland.

A further early example of the use of a counselling approach in response to a social problem can be found in the employee counselling scheme introduced in 1936 in the Hawthorne plant of the Western Electric manufacturing company (Dickson 1945; Dickson and Roethlisberger 1966; Levinson 1956; Wilensky and Wilensky 1951). In this project, counsellors were available to employees on the shop floor, to talk about any issues (both work-based and personal) that might be affecting their capacity to do their job. The rationale for the provision of counselling was that the management of the company acknowledged the pressures of working on a production line, and sought to maintain workforce well-being not only as a welfare response but also as a means of maximising productivity and reducing staff turnover. The acceptability and popularity of this service, on the part of workers, was documented in an evaluation of the scheme by Dickson and Roethlisberger (1966), which found that over a three-month period, 37 per cent of the workforce made use of counselling, with 10 per cent of those who used it reporting that it had been very helpful. It is possible to identify links between the Western Electric initiative and the ideas developed by Carl Rogers (Mahoney and Baker 2002).

These examples of critical moments in the emergence of counselling illustrate the existence of a distinct historical tradition, which has primarily arisen from a social action perspective rather than an individual pathology orientation. Although there has been much mutual interaction and influence across the counselling and psychotherapy professional communities, from a historical vantage point it is possible to see that they are each culturally positioned in somewhat different territories.

From these beginnings, counselling expanded rapidly in the latter half of the twentieth century, in terms of the membership of counselling professional bodies, the range, scope, and number of counselling agencies, and the ease of public access to counselling. A number of factors are responsible for this growth:

- The success of the earliest counselling services, in the areas of education, marital, and bereavement work, inspired groups of people to develop counselling services for a wide array of other social issues, such as suicide prevention, domestic abuse, sexual violence, drug and alcohol abuse, disability, and affirmation of sexual orientation.
- We live in a fragmented society, in which there are many people who lack emotional and social support systems that might assist them in coping with stressful problems in living – counselling fulfils a vital role in society, as a means of assisting individuals effectively to negotiate transition points in their lives.
- Counselling agencies are generally located within the communities of those whom they serve, and are networked with other caring organisations – members of the public usually know about the counselling that is available in their community, and do not feel stigmatised in making use of it.
- Counselling regularly receives publicity in the media, most of which is positive. The media image of counselling is low-key and reassuring, in contrast to, for example, the cartoon representation of the psychoanalyst.
- The legitimacy of counselling has never relied on research evidence or government policy initiatives, but instead is based on word-of-mouth recommendations by users.
- Caring and ‘people’ professions, such as nursing, medicine, teaching, and social work, which had previously performed a quasi-counselling role, were financially and managerially squeezed during the 1970s and 1980s. Members of these professions no longer have time to listen to their clients. Many of them have sought training as counsellors, and have created specialist counselling roles within their organisations, as a way of preserving the quality of contact with clients.

- Many thousands of people who work in caring professions have received training in counselling skills, as part of their basic professional education, and use these skills within an 'embedded counselling' role. There are also a large number of part-time volunteer counsellors, who combine some counselling work alongside other occupational and family responsibilities. All this creates an enormous reservoir of awareness within society of counselling methods (such as empathic listening) and values (such as non-judgemental acceptance).
- An entrepreneurial spirit exists in many counsellors, who will actively sell their services to new groups of consumers. For example, any human resource or occupational health director of a large company will have a filing cabinet full of brochures from counsellors and counselling agencies eager to provide employee counselling services.
- Counselling is a highly diverse activity, which is delivered in a broad range of contexts (voluntary/not-for-profit, statutory, private practice, social care, health, education); this diversity has allowed counselling to continue to expand at times when funding pressures might have resulted in cuts in provision in any one sector.

The emergence of counselling needs to be understood in relation to the parallel growth of psychotherapy. There have been many practitioners, from Carl Rogers onwards, who have spanned the counselling–psychotherapy divide. The majority of counselling agencies draw heavily on ideas from psychotherapy to shape their training, supervision, and practice policies. In the UK, and other countries, there are organisations, such as the British Association for Counselling and Psychotherapy, that seek to emphasise the convergence of the two professional traditions and communities. Nevertheless, counselling has retained its own identity as a distinctive practice with its own history.

As an autonomous profession, counselling has relatively recent origins. In Britain, the Standing Council for the Advancement of Counseling was formed in 1971, and became the British Association for Counselling (BAC) in 1976. The membership of the BAC grew from 1,000 in 1977 to 8,556 in 1992 (British Association for Counseling 1977, 1992). Renamed the British Association for Counselling and Psychotherapy (BACP) in 2001, at the time of publication this organisation reported over 48,000 members. The American Counseling Association was formed in 1962 and now has around 50,000 members. These figures indicate only the extent of the growth in numbers of more highly trained or professionalised counsellors in each country. There are, in addition, many people active in voluntary organisations who provide non-professional counselling and who are not represented in these statistics. And the majority of people now working in the 'human service' professions, including nursing, teaching, the clergy, the police, and many others, would consider counselling skills to be part of their work role.

It has proved difficult in many countries, including the UK, for counselling to attain full professional status in the form of state regulation and control of title. Partly this is because it has been hard to define counselling, as a separate activity from psychotherapy or psychology, and also because members of other established professions, such as nursing or social work, can claim that they fulfil a counselling role. A study of the history of the professionalisation of counselling in Britain concluded that the counselling profession can be viewed as a 'self-effacing' occupational group (Aldridge 2011). Other professions, such as law, medicine, and the clergy, are highly assertive in claiming their possession of specialist knowledge, and their right to be sole providers of specific services. Counselling, on the other hand, consists of a set of skills and ideas that are to some extent shared by all 'people-facing' occupations.

## The emergence of other professional identities

This chapter has focused on the historical emergence and development of counselling and psychotherapy. It is important to acknowledge that this is a partial account; a more comprehensive version

would include the stories of the role of therapy as a specialist area within professions such as social work, psychiatry, and mental health nursing. It is also necessary to acknowledge the significance of three professional groupings that are closely linked to counselling and psychotherapy, but maintain separate professional identities: career counselling, coaching, and embedded counselling.

The early origins of career guidance and counselling were highlighted in an earlier section of this chapter – the work of Frank Parsons around assisting individuals to make career choices was a key factor in the development of counselling as a specialist occupation and then as a profession. Career guidance and counselling have maintained an autonomous professional identity (Engels et al. 1995; Pope 2000; Savickas 2008). While drawing on skills and theories found in generic counselling and psychotherapy, career counselling includes a number of distinctive features, such as the use of vocational choice inventories, close involvement with government departments and policies in areas such as education and business, and an explicitly strength-based, developmental orientation. Career guidance and counselling has therefore evolved as an independent profession, with its own professional associations, journals, training programmes, and international networks (Arulmani et al. 2014; Athanasou and van Esbroeck 2008; Brown and Lent 2005). Regrettably, theory and research in career counselling has had a rather limited impact on the broader field of counselling and psychotherapy. This is regrettable, since it has resulted in an absence of recognition, in the therapy world as a whole, of the ways in which life satisfaction and personal meaning are shaped by the experience of work.

The concept of ‘coaching’ refers to a form of helping relationship that incorporates a combination of teaching, mentoring, support, and counselling. Historically, coaching has mainly been taken to refer to sports coaching. More recently, a variety of coaching has been developed that focuses on assisting individuals to achieve their potential in any walk of life. Although this type of coaching has been particularly popular and successful in the field of business and management (Cox et al. 2013; Rogers 2016), it has also been applied in areas such as health and family functioning. As with career counselling, coaching is based in skills and theories from counselling and psychotherapy, augmented by ideas and practices from fields such as education and learning, management studies, gender studies, and positive psychology (Wildflower 2013; Wildflower and Brennan 2011). Unlike career counselling, coaching has not yet coalesced into a unified professional identity or structure. For example, some leading figures have advocated that it should be regarded as an area of applied psychology, whereas others believe that it requires recognition as a distinctive interdisciplinary grouping.

Possibly the largest set of providers of psychotherapeutic help are health professionals, teachers, social workers, and others who use counselling skills and therapeutic perspectives within their primary professional roles. This kind of activity has been described as ‘situated’ (Høigaarda and Mathisen 2008) or ‘embedded’ (McLeod and McLeod 2011) counselling. While there exist many training courses targeted at such practitioners, and a substantial body of research evidence around the process and outcomes of their interventions (McLeod and McLeod 2015), there have been no professional associations or other organisational structures that have evolved to support this kind of work.

### **Box 22.4: Where have we got to now? How much therapy is there?**

Because of the many different types of therapy provider there are, it is hard to measure the amount of counselling or psychotherapy that is available within society. It is probably even harder to estimate the potential demand for therapy. There have been attempts to estimate the proportion of subgroups of the population using therapy in different countries (for example, Blay et al. 2015; Kirkwood 2000; Olfson and Marcus 2010; Olfson and Pincus 1999). Although

the proportion of the population who use therapy varies across gender, social class, and ethnicity, it would appear that between 4 and 10 per cent of people make use of therapy in any one year. How large is the potential demand for therapy? Research carried out by Goldberg and Huxley (1992), Wittchen and Jacobi (2005), and others suggests that at any one time, around 25 per cent of the population describe themselves as suffering from psychological problems. A national survey undertaken by Anderson and Brownlie (2011) in the UK reported that around one in three of the population regarded counselling or psychotherapy as something that they might use if they had a problem; around one in three reported that they would be very unlikely to use a counsellor under any circumstances, and the remainder held mixed views (see also S. Anderson et al. 2009).

Another means of estimating the demand for counselling and other psychological therapies is to monitor waiting times. In the UK, it is not uncommon for National Health Service (NHS) specialist psychotherapy services to have waiting times of over 12 months, or for voluntary sector counselling agencies to decide to close their waiting lists as a means of controlling demand. There is evidence that people who would prefer psychotherapy are increasingly offered medication as a cheaper alternative (see, for example, Olfson and Marcus 2010). Putting all these figures together, it seems likely that in modern industrialised societies, there is about one full-time counsellor or psychotherapist for every 2,000 of the population, and that there is an unmet demand for therapy services because of cost, waiting times, and other obstacles.

## Towards a transcultural history of therapy

The historical account given here is inevitably incomplete and partial, in being almost entirely oriented towards what happened in Europe and North America. Analysis of the history of counselling and psychotherapy in African, Asian, and South American countries has the potential to yield further valuable insights into the ways in which therapy theory and practice has been shaped by social, cultural, political, and historical factors (Marks 2017; Pols 2018). Martin (2018) has argued that in order to understand contemporary psychotherapy as a global phenomenon, it is necessary to take account of local and regional histories that have been discounted. For example, he points to the development of a culturally informed Indian approach to psychoanalysis that was never taken seriously by the leading figures in the psychoanalytic movement. Another important dimension of a transcultural approach to the history of counselling and psychotherapy involves the way that therapists needed to conform to authoritarian Communist state control in Russia and China, and what then happened when each of these countries adopted more market-oriented economic systems (Marks 2018; Matza 2012; Zhang 2014).

## Conclusions

Counselling and psychotherapy can be regarded as a mirror of society, in that therapeutic work of any kind highlights aspects of social life that have been particularly problematic at that particular time. Freud brought into the open the sexual oppression of the Victorian era, Rogers and many other therapists in the 1950s wrote about the confusion around self and identity that was triggered by post-war economic expansion, while contemporary therapists draw attention to the depression, hopelessness, racism, gender role conflict, and sexual violence that characterise present-day society.

Counselling and psychotherapy each play an active role within society, in shaping people to become the type of citizens, workers, or consumers that are required at any specific time and place.

For example, psychoanalysis, with its emphasis on the potentially destructive impact of parents on their children, was just what was needed around the beginning of the twentieth century, when economic and scientific progress required people to take on quite different work roles from those held by their parents. In the 1960s, the new consumerism required people who could reflect and choose – qualities that were promoted by both client-centred and cognitive therapies. The threat of global warming and economic austerity, in the first decades of the twenty-first century, have stimulated calls for a return to spiritual values and practices, and to more collective ways of life – trends that are exhibited in the popularity of mindfulness therapies and narrative therapy. The mode of delivery of therapy has also been determined by social factors. In Freud's time, when users of therapy were upper-class individuals with plenty of leisure time and money, it made perfect sense to provide long-term therapy on a daily basis. In modern times, when psychotherapy is provided by health organisations seeking to assist people back to work, brief time-limited therapy has become dominant.

The key cultural themes that have stimulated the historical development of counselling and psychotherapy, and related professions, include:

- the increase in individualism and alienation within modern societies, accompanied by an erosion of collective/communal ways of life and forms of support;
- for individuals, a sense of fragmentation in their sense of self, accompanied by a striving to achieve wholeness and identity;
- pressure on individuals to act rationally and control their emotions, in order to conform to the demands of the modern workplace;
- the ever-expanding number of lifestyle and consumer choices that must be made;
- the replacement of spiritual/religious systems of making sense of life by scientific models;
- an increasing emphasis on medical solutions to social and personal problems.

Further exploration of these themes can be found in a wide range of sources: Bauman (2004), Furedi (2004), Gergen (1991), Giddens (1991), Kvale (2003), Madsen (2014), and Rose (1996, 1999).

Behind the social and cultural construction of psychotherapy, there are two basic assumptions. The first assumption is that unhappiness is bad, and that we all deserve to be happy (Illouz 2007, 2008). The assumption of entitlement to happiness is reflected within psychotherapy research, in the universal use of symptom change (i.e. unhappiness indicators) to assess the effectiveness of therapy. The second assumption is that unhappiness can be fixed and sorted by changing the individual. In the main, counselling and psychotherapy have emerged from a long historical journey, on the part of Western societies, in the direction of self-contained *individualism* (Baumeister 1987; Cushman 1990, 1995; Logan 1987). This assumption is reflected in the ideas and practices of the majority of schools of psychotherapy, and in the proliferation of what Gergen (1990) has characterised as the 'language of deficit' – the capacity of psychologists, psychiatrists, and psychotherapists to describe a myriad of patterns of psychological dysfunction within individual persons.

A historical perspective deepens our appreciation of the writings of seminal figures such as Freud and Rogers cannot be gleaned from textbooks (such as this one) but require close reading of their early cases, which illustrate the radical nature of what it was they actually did (rather than the tidied-up version that has become part of accepted wisdom).

Finally, the history of therapy highlights the multiple ways of making sense of personal troubles that exist within modern society – and how they can be resolved. We live in a world in which problems in living may be understood, by different individuals and groups, as resulting from a lack of faith, a biological illness, a failure of learning or family support, a crisis in personal growth, or a response to hardship and adversity. Each of these perspectives represents a specific historical moment or discourse that continues to co-exist as one layer in a complex archaeology of knowledge. The existence of such a fragmented mosaic of ideas has resulted in the diversity of psychotherapeutic theory and practice that is apparent in contemporary society.



## Topics for reflection and discussion

- 1 Select a counselling or psychotherapy agency or service with which you are familiar. What do you know about the historical development of that agency? To what extent can its creation be understood in terms of the themes discussed in this chapter? What is the social role of the agency within its community?
- 2 Ask people you know to give you their definition of terms such as 'counsellor', 'psychotherapist', 'hypnotherapist', 'psychiatrist', 'life coach', and 'career counsellor'. Invite them to tell you what they believe happens when someone consults one of these professionals. What are the social, cultural, and historical origins of the images and ideas you elicit?
- 3 What is the relationship between religious beliefs (and/or spirituality) and counselling/psychotherapy in your own personal life, and in your professional work?
- 4 The historical studies reviewed in this chapter have largely focused on factors that shaped the development of counselling and psychotherapy in the USA. What are the different historical factors and events that have shaped the development of therapy in other societies with which you are familiar, and what are the implications of these historical perspectives for current policy and practice in these countries?

## Suggested further reading

The book that brings together many of the themes of this chapter in a compelling and authoritative manner is Phillip Cushman's (1995) *Constructing the Self, Constructing America: A Cultural History of Psychotherapy*. This is possibly the only book currently available that offers a critical account of the historical development of therapy. It is largely American oriented, and has little to say about Europe, or indeed about counselling. But it is a rattling good read – thought-provoking and horizon-widening.



# Chapter 23

## Culturally sensitive therapy

<b>Introduction</b>	<b>339</b>
<b>What do we mean by 'culture'?</b>	<b>339</b>
The concept of reality	341
The sense of self	341
The construction of morality	342
The concept of time	342
The significance of place	343
Externally observable dimensions of cultural identity	344
Overview: dimensions of cultural experience	345
<b>The diversity of cultural beliefs and practices around how to handle problems in living</b>	<b>345</b>
Culture-bound syndromes	345
Culturally diverse healing practices	346
<i>Ritual healing: a Ndembu doctor</i>	347
<i>Counselling in the Chinese temple</i>	347
<i>Healing lament in Finland</i>	347
<i>Naikan therapy in Japan</i>	348
<i>Maori philosophy of life</i>	348
<i>Native American sweat lodge ceremonies</i>	348
Implications of culturally diverse healing practices	349
<b>Cultural identity and intersectionality</b>	<b>350</b>
<b>Culturally sensitive therapy in action</b>	<b>351</b>
General strategies	351
Cultural curiosity and humility	352
Broaching: initiating conversations about cultural issues	353
Ethnic/cultural client–therapist matching	354
Adapting or developing services and agencies to meet the needs of client groups from different cultures	357
Guidelines and competencies	359
<b>Conclusions</b>	<b>360</b>
<b>Topics for reflection and discussion</b>	<b>361</b>
<b>Suggested further reading</b>	<b>361</b>

## Introduction

One of the defining characteristics of the contemporary world is the inescapable salience of cultural difference. In earlier times, it was much more possible to live as a member of a relatively isolated and self-contained social class or group, and remain relatively unaware of, and be unaffected by, the existence of different ways of life. In recent years, all this has changed. Increasingly, members of so-called 'ethnic minority' groups have become unwilling to be treated as a marginalised, disadvantaged, and politically disenfranchised segment of the labour force, and have claimed their voice and their power within society. Members of privileged groups have become more aware of the questionable moral status of what had previously been experienced as a taken-for-granted sense of entitlement. At the same time, the process of globalisation, including the spread of global communications media such as the internet and satellite television, and the growth of international air travel, have resulted in a huge increase in accessibility of information about other cultures. The images and sounds of other cultures are now available in ways that were not possible before. It is impossible to deny that we live in a multicultural world.

Counselling and psychotherapy have responded to the trend towards multiculturalism in two main ways. The original, foundational approaches to therapy – for example, the psychodynamic, person-centred, and cognitive-behavioural models – were clearly 'monocultural' in nature. They were designed and applied in the context of Western (mainly American) industrial society, and had little to say about culture or cultural difference. In the 1960s and 1970s, the counselling and psychotherapy community attempted to react to the political, legislative, and personal pressures arising from the equal opportunities movement and debates over racism and equality by developing strategies for building a greater awareness of cultural issues into therapy training and practice. This phase, which generated a substantial literature on 'cross-cultural', 'transcultural', and 'intercultural' approaches to counselling and psychotherapy, represented an attempt to assimilate a cultural dimension into mainstream practice. Through this process, many 'culturally adapted' models of therapy have been developed, implemented, and evaluated. Useful though these efforts have been in legitimating the experiences and needs of 'minority' clients and therapists, it can be argued that they do not go far enough.

A second response to the issues raised by an awareness of cultural difference has been, therefore, to strive to construct an approach to therapy that places the concept of 'culture' at the centre of its 'image of the person', rather than leaving it to be 'tacked on' as an after-thought. This new, *multicultural* approach (Pedersen 1991) starts from the position that membership of a culture (or cultures) is one of the main influences on the development of personal identity, and that the emotional or behavioural problems that a person might bring to therapy are a reflection of how relationships, morality, and a sense of the 'good life' are understood and defined in the culture(s) in which a person lives their life. Pedersen (1991) argued that multiculturalism should be regarded as a *fourth force* in psychotherapy, complementing and superseding the three earlier movements of behaviourism, psychoanalysis, and humanistic psychology.

The present chapter seeks to provide an overview of where we are now in relation to being able to make sense of the cultural contexts within which therapy takes place. This is not a linear story, of progress towards more satisfactory and effective forms of practice. Instead, this journey has been, and remains, a struggle in which some remarkable insights and gains are set against ongoing indifference.

## What do we mean by 'culture'?

It is important to avoid any temptation to oversimplify the concept of culture. At one level, culture can be understood simply as 'the way of life of a group of people'. In any attempt to understand 'culture', it is necessary to make use of the contribution made by the social science discipline that has specialised in the task of describing and making sense of different cultures: social anthropology (Ingold 2018). A central assumption in social anthropological research has always been to take

the view that it is only possible to do justice to the complexity of a culture by living within it for a considerable period of time, and carrying out a systematic and rigorous observation (ethnography) into the way that the members of that culture construct the world that they know through processes such as kinship networks, ritual, mythology, and language. In the words of Clifford Geertz (1973), to understand a culture it is essential to take account of what lies beneath the surface: the web of meaning and 'inherited conceptions' that are symbolised and expressed in outward behaviour. The external manifestations of culture can be literally anything: work patterns, the design of Coke bottles, the performance of religious rituals. Everything that members of a culture do represents some aspect of what life means to them. And this meaning has historical roots. It has evolved and been shaped over many years and permeates the language people use and the artefacts they create. The image that Geertz (1973) uses to capture all this is that of culture as 'thick' – an appreciation of a culture requires the construction of a 'thick description'.

This idea that the culture within which a person exists is complex and, by implication, difficult to understand, has important implications for counsellors and psychotherapists. An anthropologist would spend months or years working towards an adequate appreciation of what things mean to a person from another culture. A therapist attempts to achieve the same goal in a much shorter period of time. Moreover, a therapist will seldom have an opportunity to observe their client interacting within their own cultural milieu; therapy takes place in the world of the therapist (their office). For these reasons, it is necessary for therapists to be cautious, and modest, about the extent to which they can ever hope fully to enter the cultural reality inhabited by the client.

It can be argued, therefore, that the basis for any kind of culturally sensitive therapy is *not* exhaustive training in the culture and norms of different groups of people – this is not realistic. Instead, the core of culturally sensitive therapy is the possession of a general framework for making sense of the possible ways in which different cultures function and interact, allied to a genuine *curiosity* (Falicov 1995) and *humility* (Hook et al. 2013) about the lives and cultural experience of other people.

The aim is not to be able to analyse the 'objective' cultural world of a client, but to be able to appreciate their *cultural identity* – how the person sees themselves in cultural terms. Lee (2006) has defined cultural identity as a 'sense of belonging' to a cultural group. Cultural identity plays a crucial role in shaping and maintaining the way that a person seeking therapy defines problems and solutions, and the assumptions that they hold about what it means to be a person, and what it means to be in relationships. To be truly open to the cultural identity of a client or service user, a counsellor or psychotherapist first needs to be curious and informed about their own cultural identity.

Although the lived experience of being a member of a culture is 'seamless' and unified, it is nevertheless useful for purposes of clarity to try to list some of the most important features of cultural identity. It can be helpful to differentiate between underlying, all-pervasive aspects of culture, and specific observable or behavioural manifestations or expressions of these themes. In respect of underlying beliefs and assumptions, key areas include:

- how reality is understood (e.g. dualistic or holistic);
- concept of self (autonomous, bounded, referential vs. social, distributed, indexical);
- sense of morality (e.g. choice vs. fate, values);
- concept of time (linearity, segmented, future-oriented, respect for elders);
- sense of land, environment, place.

Salient aspects of externally observable dimensions of culture include:

- non-verbal behaviour, eye contact, distance, gesture, touch;
- use of language (e.g. reflexive and analytic vs. descriptive; linearity of storytelling);
- kinship and relationship patterns (what is the most important relationship?);
- gender relationships;

- expression of emotion;
- role of healer and theory of healing.

For a culturally sensitive therapist, these features represent a kind of mental ‘checklist’ through which the world of the client can be explored, and an appropriate and helpful mutual client–therapist world can be constructed.

## The concept of reality

At the most basic level of understanding and comprehension, people in different cultures possess different ideas about the fundamental nature of reality. In Western cultures, people generally hold a *dualistic* view of reality, dividing up the world into two types of entity: mind and body. The mind is ‘disembodied’, and consists of ideas, concepts, and thought. The physical world, on the other hand, is tangible, observable, and extended in space. Many writers have argued that it is this mind–body split, originally formulated by the French philosopher Descartes in the sixteenth century, that has made possible the growth of science and the resulting highly technological way of life of people in Western industrial societies. It is also a philosophical position that limits the role of religious and spiritual experience and belief, since it assigns the study of the physical world to science, and therefore places it outside of the realm of the ‘sacred’. In terms of social relationships, dualism has had the impact of increasing the division between self and object, or self and other. The ‘self’ becomes identified with ‘mind’, and set against and apart from the external world, whether this be the world of things or of other people.

In most world cultures, people do not have a dualist conception of the nature of reality, but instead experience the world as a wholeness, as a unity. The philosophical systems associated with Buddhism, Hinduism, and other world religions all adopt this position, in which the physical, the mental, and the spiritual are understood as aspects or facets of a single unified reality, rather than as separate domains of being.

It might appear as though discussions of the nature of reality are esoteric and obscure, and relate only to the interests of those few people who engage in philosophical discourse and debate. Far from it. The person’s understanding of reality cuts through everything that happens in therapy. For example, a dualistic Western culture has generated many terms and concepts that refer solely to mentalistic phenomena: depression, anxiety, guilt. These terms do not exist in cultures where there is a more holistic view of things. In these cultures, the person’s response to a difficult life situation will be expressed in terms that are primarily physical. An Asian person experiencing loss, for instance, might go to a doctor and complain about physical aches and pains. A European undergoing the same life event might present themselves as depressed. The core elements of therapy, the words that the person uses to describe their ‘troubles’, reflect the underlying, implicit, philosophical viewpoint of the culture to which the person belongs. Not only that, but the concept of healing espoused in a culture depends on whether it is dualist or holist. In Western dualist cultures, it makes sense merely to talk about problems, to engage in a ‘mental cure’. In cultures built around a unity of mind, body, and spirit, healing practices will engage the person at all these levels, possibly encompassing activities such as meditation, exercise, and diet. The Hindu discipline of yoga is an example of a method of healing, learning, and enlightenment that operates in this kind of holistic manner. Finally, a Western dualistic concept of reality implies that the stuff of life is either physical, material, and mechanical, or is subjective and psychological. There is little space here for a dimension of reality that is transcendental, sacred and spiritual.

## The sense of self

The sense of what it means to be a person varies across cultures. As discussed in Chapter 22, counselling and psychotherapy have primarily developed within cultures that espouse an understanding of the person as being an autonomous, separate individual, with strong boundaries and an ‘inner’,

private region of experience. Landrine (1992) has described this definition of self as *referential*: the self is referred to as an inner 'thing' or area of experience. Landrine (1992) contrasts this notion with the *indexical* experience of self found in non-Western or 'sociocentric' cultures: the 'self' in these cultures is not an entity that exists independently from the relationships and contexts in which it is interpreted. On the contrary, a person's sense of self depends for its existence on a network of relationships.

Sampson (1988) is among many theorists who have commented on the difference between the *individualist* concept of self that predominates in Western societies, and the *collectivist* approach that is part of traditional cultures and ways of life. This distinction is similar to the concepts of *agency* and *communion* used by Bakan (1966). The person in a collectivist community is likely to regard themselves as a member of a family, clan, or other social group, and to make decisions in the light of the needs, values, and priorities of this social network. Concepts such as self-actualisation or authenticity (being true to one's individual self) do not make a lot of sense in the context of a collectivist culture. Conversely, notions of honour, duty, and virtue can seem archaic within modern individualist cultures. Individualist cultures emphasise the experience of guilt, referring to an inner experience of self-criticism and self-blame. People in collectivist cultures are more likely to talk about shame, referring to situations where they have been found wanting in the eyes of a powerful other person. It can be very difficult for people from extreme individualist or collectivist cultures to understand each other (Pedersen 1994). In practice, however, most cultures – and most individuals – comprise a mix of individualist and collectivist tendencies, so that, for example, a counsellor brought up in a highly individualist environment should be able to draw on some personal experiences of collective action when working with a client from a more collectivist background.

## The construction of morality

Making moral choices, deciding between right and wrong, is central to life. However, the moral landscape is constructed quite differently in different cultures. The key characteristics of modern Western morality are a belief in individual choice and responsibility, and a willingness to be guided by abstract moral principles such as 'fairness' or 'honesty'. By contrast, in traditional cultures, moral issues are much more likely to be decided through consideration of the operation of *fate* (e.g. the Hindu notion of *karma*), and moral teachings or principles are embedded in stories rather than articulated through abstract concepts. The choice–fate distinction is crucial in many counselling situations. One of the goals of person-centred and other approaches to counselling and psychotherapy is to help the person to discover or develop their 'internal locus of evaluation', their capacity to make moral choices on the basis of an individual set of values. It is not hard to make a connection between this definition of moral choice and the image of the present-day individual as consumer depicted by Cushman (1990, 1995) and others. Most therapists would seek to question or challenge a client who continues to attribute their actions to fate, and denies any personal responsibility. Most traditional healers would, conversely, regard a person who insisted that their problems were due to individual choices as stubbornly self-centred and unwilling to admit the extent to which ancestors or spirit presences were determining their life.

Another dimension of cultural contrast can be found in the area of *moral values*. Individualist cultures tend to promote values such as achievement, autonomy, independence, and rationality. Collectivist cultures place more importance on sociability, sacrifice, and conformity.

## The concept of time

It has been one of the great contributions of existential philosophers to review the significance for individuals and cultures of the way that *time* is experienced. From the perspective of physics, time can be treated as a linear constant, segmentable into units such as seconds, minutes, and hours. From the perspective of persons and social groups, time is one of the elements through which a

way of being and relating is constructed. One of the defining characteristics of modern industrial societies is the extent to which they are *future-oriented*. The past is forgotten, destroyed, built over. Oral history, the story of what a family or community achieved in the past, survives only to the most minimal degree. The past is re-defined, packaged, and sold as 'heritage'. Traditional, collectivist societies, by contrast, are predominantly *past-oriented*. There is a strong continuity in the oral history that is available to members of traditional cultures. It is normal to imagine that ancestors are in some sense present and can communicate with the living. In modern cultures, the notion of *progress* is given a great deal of value. The practices, lifestyle, and possessions of previous generations are considered 'old-fashioned' and 'dated'. In traditional cultures, 'progress' and development can often be perceived as threatening. The forms of communication and storage of information, and types of work tasks, in different cultural settings also have an impact on the experience of time. In pre-literate cultures, it makes sense to assume that everyday life was lived largely in the moment, focused on tasks that required attention in the here-and-now. In modern technological societies, there is a spectrum of activities, including reading and watching television, that unavoidably shift the consciousness of the person to 'there-and-then'. There is some irony in the attempts of humanistic psychologists and therapists, in the mid-twentieth century, to create methods of enabling people to rediscover the *present moment*.

The influence of modern attitudes to time lies at the very heart of therapy. Implicit, and often explicit, in the practice of much psychodynamic and humanistic counselling and psychotherapy is an invitation to the client to confront and reject the authority of their parents, who are regarded as responsible for the inculcation of repressive and life-restricting injunctions and patterns of behaviour. This way of seeing relationships between parents and children is consistent with the pervasive ageism of contemporary society and with the need for an advanced capitalist economy to encourage citizens to consume new and different products and adopt new work patterns and roles. It does not sit easily, however, with the past-centred reverence for parents and ancestors widespread in non-Western cultures. The construction of time in different cultural settings can have very practical consequences. In cultures where linear, segmented, clock-defined time is dominant, it makes sense for therapy clients to be given hour-long appointments at the same time each week. In some other cultures, these arrangements just do not make sense, and clients would expect to be able to drop in to see a therapist when it feels right to them, rather than when the clock or calendar dictates they should.

## The significance of place

The final dimension of culture to be discussed here concerns the relationship between cultures and the physical environment, the land. It is clear that the bond between person and place has been largely severed in modern urban societies. Social and geographical mobility is commonplace. People move around in response to educational and work opportunities. Transport and relocation are relatively easy. As a result, there are few people who live as adults in the same neighbourhood or community in which they grew up, and even fewer who live in the neighbourhoods or communities where their parents or grandparents grew up. While modern cultures retain some appreciation of place, this tends to be from a detached, observer perspective, such as in the form of transferable ownership and tourism. All this means that it can be enormously difficult for counsellors and psychotherapists socialised into the ways of modernity to understand the meaning of place for people from different cultural backgrounds.

Research into both traditional and modern industrial-urban cultures has established that place and land can have a powerful emotional and social significance for people (M. Smith et al. 2009; Walker et al. 2017). These aspects of human experience are, however, largely ignored by Western psychology and approaches to counselling and psychotherapy. It does not need much reflection to confirm that place is often extremely important for members of modern industrial-urban societies. People invest a great deal of energy in their homes and gardens, and in their relationship with the countryside.



## Externally observable dimensions of cultural identity

Turning now to more immediately observable and overt aspects of culture, it is clear that many of the underlying philosophical dimensions of different cultural 'worldviews' are expressed and visible in the ways that people behave. One observable aspect of cultural difference that has received substantial attention is *non-verbal behaviour*. Cultures can be differentiated in terms of the way that people employ non-verbal cues such as touch, eye contact, gesture, and proximity. Often, the difficulties in communication that exist between members of separate cultural groups can be understood through an appreciation of non-verbal factors. For example, direct eye contact is considered in Western cultures as a sign of honesty and openness, but in many other cultures would be perceived as rude or intrusive. Similarly, each culture employs complex unwritten rules about who can be touched and in what circumstances.

Important cultural differences can also be observed in patterns of *verbal behaviour*. Classic early research by Bernstein (1972) examined linguistic differences between working-class and middle-class subcultures in English society, and found that, when asked to tell a story based on a series of pictures, middle-class people tended to use what he called an 'elaborated code', in which they explained the assumptions behind their understanding of the situation. Working-class participants in his study, by contrast, seemed to use a 'restricted code', in which they took for granted that the listener would 'know what they meant'. Landrine (1992) has suggested that people from 'referential self' cultures talk about themselves in abstract terms, as an object with attributes (e.g. 'I am female, a mother, middle-aged, tall, a librarian'), whereas those immersed in 'indexical self' social life find it very difficult to do this. When asked to talk about themselves they are much more likely to recount stories of specific concrete instances and episodes that express these qualities in dramatic form. People from different cultures have quite distinct modes of storytelling. Western individuals tend to tell well-ordered, logical, linear stories. People from more orally based traditional cultural groups tend to tell stories that are circular and never seem to get to the 'point'. These are just some of the many linguistic aspects of cultural difference. The key point here is that the way that a person talks, the way that they use language, conveys a great deal about their cultural and personal identity.

A feature of social life to which anthropologists have paid a great deal of attention is *kinship patterns*. There are a series of issues around this topic that are fundamental to the construction of identity in members of a culture: What is the size and composition of the family group? How are marriages arranged? Who looks after children? How is property passed on from one generation to another? From the point of view of a counsellor or psychotherapist, the answers a person gives to these questions help to generate a picture of the kind of relational world in which they expect to live, or which is regarded as normal. A powerful way of illustrating differences in kinship ties is to ask: what is your most important relationship? In Western cultures, the answer will often be that the most important relationship is with the spouse or life partner. In other parts of the world, the closest relationship is between parent and child.

Very much linked in with kinship patterns is the issue of *gender relationships*. The influence of gender on personal identity is immense, and some feminist theorists would even argue that gender is more central than culture to understanding the way that a person thinks, feels, and acts. Nevertheless, it is also clear that gender identity and gender roles are constructed differently in different cultures. Included within the cultural definition of gender is the extent to which a culture represses, tolerates, or celebrates gay, lesbian, and other non-heteronormative forms of sexual activity.

The *expression of emotion* is a facet of enculturation that is central to counselling and psychotherapy. Different cultures have varying understandings of which emotions are 'acceptable' and are allowed expression in public. One way that the 'emotional rules' of a culture can be observed is through the range of words that a person has available to describe emotions and feelings. It is clear, from research carried out by anthropologists and cross-cultural psychologists, that emotion or feeling words or facial expressions in one culture do not map easily on to the language of another culture. For example, in the Shona (Zimbabwe) language the term *kufungisisa* (roughly translated

as ‘thinking too much’) is widely used to account for psychological problems, but has no direct equivalent in English. Farooq et al. (1995), and many other researchers, have found that people from Asian cultures tend to express depression and anxiety through bodily complaints and ailments rather than in psychological terms. These examples represent one of the key challenges for multi-cultural therapy: to what extent can anyone know how someone from another language community *really* feels?

The final observable manifestation of cultural difference to be discussed is the area of attitudes and practices around healing. Every culture has its own understanding of well-being, illness, and cure. The *theory of healing* espoused by members of a culture can be based on scientific knowledge, as in Western industrial societies, or can be grounded in supernatural beliefs. In many cultures, traditional/spiritual and modern/scientific approaches to healing may exist side by side.

## Overview: dimensions of cultural experience

The concepts of perspectives discussed in this section of the chapter underscore the fact that there is no simple way to understand culture. Effective culturally sensitive or culturally responsive counselling and psychotherapy is built around an acknowledgement of the enormous complexity of cultural identity, beliefs, and behaviour. Culturally informed therapy involves not only being able to ‘see’ people in cultural terms, but also having a capacity to apply this understanding to the task of helping people with their problems. It is impossible for a counsellor or psychotherapist to know about all cultures. What is more useful is to know the right questions to ask. It can be dangerous to imagine that it is even possible to build up a comprehensive knowledge base about a cultural group – for instance, through reading, attending a university class or workshop on a training course – because within that cultural group there will certainly be a myriad of varying strands of cultural experience. Probably the best that can be achieved by training workshops or book chapters on the counselling needs and issues of particular groups is to provide a starting point that sensitises the therapist to the structures, language, and traditions of that group. Beyond that, it is necessary to fill in the details with the help of each client, who possesses their own unique set of cultural values and experiences.

## The diversity of cultural beliefs and practices around how to handle problems in living

It seems reasonable to assume that all people, in all cultures, experience broadly the same kinds of difficulties in making their way through life – conflicts with family members and co-workers, loss of motivation and meaning in response to setbacks, the development of fears and anxieties when faced with threat, and so on. The majority of people grow up in a specific cultural environment in which they are exposed to a particular way of understanding and handling such issues. One of the key steps in the development of culturally aware therapy is the realisation that there exist many different patterns of cultural beliefs and practices around how to handle problems in living. The following sections explore cultural diversity from two angles. First, there is a brief introduction to the idea of ‘culture-bound syndromes’. Second, some examples of healing practices are described.

### Culture-bound syndromes

Even though all human beings are biologically and neurologically structured in the same way, there exist different types of psychological and emotional problems in different cultures. It probably makes sense to regard the consequences of problems in living, in all cultures, as falling into broad patterns of thought, feeling, and action associated with the experience of fear/anxiety, sadness/loss/depression, and breakdown of meaning (psychosis). However, the form that these reactions

take appears to be significantly influenced by cultural factors, with the result that a large number of distinct psychiatric ‘culture-bound syndromes’ have been identified within various communities.

When considering the topic of culture-bound syndromes, it is useful to take into account that the way that patterns of psychological problems are understood in contemporary Western society does not in fact remain static. Current ideas about psychiatric diagnostic categories only began to be formulated at the start of the twentieth century. Cushman and Gilford (1999) discuss ways in which revisions to the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association reflected shifts in the cultural milieu. A striking example of this is the inclusion, then exclusion, of homosexuality as a category of psychiatric disorder. It is possible to see, therefore, that there are no fixed definitions of patterns of psychological and emotional problems, but that ideas about these topics depend on values and ideas that prevail in a particular community or society at a particular point in time.

A well-studied example of a culture-bound syndrome is *shinkeishitsu*. This is a pattern of distress and dysfunction reported by people in Japan (Ishiyama 1986; Russell 1989), characterised by self-preoccupation, high levels of sensitivity to health symptoms, perfectionist self-expectations and high achievement motivation, and a rigid worldview. Although *shinkeishitsu* has some similarities to the Western concept of anxiety disorder, it also encompasses unique features arising from the trends towards conformity and social acceptance that are found in Japanese culture. A more recent culture-bound syndrome that also has its roots in Japanese culture, but has spread to other societies, is *hikikomori* syndrome (Kato et al. 2012; Tateno et al. 2012). This is a pattern that is typically found in young men, who completely withdraw from society for at least six months.

Another example of a culture-bound syndrome is *ataques de nervios*, which is prevalent in some areas of Latin America such as Puerto Rico. *Ataques de nervios* is characterised by a sense of being out of control. The person may shout, cry, engage in verbal or physical aggression, or exhibit seizures or fainting episodes. This tends to occur when a person has learned of bad news concerning their family, such as a tragic bereavement or accident. The person may not remember what they did during the attack, and will typically return to normal after a short time (Guarnaccia and Rogler 1999).

In Nigeria, *brain fog* syndrome is a widely used term, which refers to a mix of insomnia, physical aches and pains, and difficulty concentrating that is found in young people who are under stress (Ayonrinde et al. 2015). Eating disorders such as *bulimia nervosa* and *anorexia nervosa* are culture-bound syndromes originating in Europe and North America (Keel and Klump 2003) even though cultural globalisation has meant that they are now found virtually everywhere. *Djinatti* syndrome, found in many Asian cultures, consists of a trance or dissociative state in which the person is possessed by a spirit or fairy (Bakhshani et al. 2013). *Dhat* syndrome, found in the Indian subcontinent, refers to symptoms in men of fatigue, weakness, anxiety, loss of appetite, guilt, and sexual dysfunction attributed by the individual to loss of semen in nocturnal emissions (Sumathipala et al. 2004).

There are other culture-bound syndromes that have been identified, but have not received a specific label. An example of this is the expression of uncontrollable rage by women in war-torn regions (Rees et al. 2013). There are other syndromes that are recognisable but do not appear to have been deemed as discrete syndromes. An example of this would be an obsessional interest in guns followed by the mass killing of strangers in public places. This pattern occurs regularly in the USA, and to a lesser extent in other countries. There is evidence that, in some groups, traditional culture-bound syndromes are gradually being replaced by internationally defined psychiatric categories and language (Greener 2017).

## Culturally diverse healing practices

The following vignettes offer examples of widely different forms of emotional healing, or ‘therapy’ in different cultural settings.

### *Ritual healing: a Ndembu doctor*

Victor Turner was one of the leading figures in twentieth-century social anthropology. His analysis of shamanistic healing in the Ndembu (a traditional community who resided in the intersection of what is now Zambia, Congo, and Angola) is one of the most widely read examples of anthropological participant observation research (Turner 1964). A young man within the tribe, Kamahasanyi, had fallen out with other members of the group, and had become ill, complaining of debilitating heart, back, limb, and chest pain. The local doctor or shaman, Ihembi, was called in and, following extensive interviewing of his patient, arranged a complex, sustained ritual event that involved all members of the tribe. The event incorporated drumming, dancing, animal sacrifice, and use of herbal hallucinogens. In the midst of this increasingly intense physical and emotional process, Ihembi encouraged both Kamahasanyi and other members of his family and community to tell their stories about what had been happening in their relationships, and to express their feelings and grievances. The climax of the event was the discovery by Ihembi of a tooth in Kamahasanyi's body, which he announced was responsible for his illness because it was a source of ancestral 'shades' or spirits from earlier times. The following day, Kamahasanyi was much better, was able to resume work, and harmony was restored in the village as a whole.

### *Counselling in the Chinese temple*

In Taiwan, people in crisis may choose to visit the temple to seek advice through *chouchien* (fortune-telling through the drawing of bamboo sticks). The *chien* client makes an offering to the temple god, tells the god about their problems, then picks up and shakes a bamboo vase containing a set of *chien* sticks. One of the sticks becomes dislodged, and is selected. The client then throws a kind of die to determine whether they have drawn the correct *chien*. Once sure that they have chosen the right stick, they take it over to a desk in the temple and ask for the *chien* paper corresponding to a number inscribed on the stick. On the paper there is a classical short Chinese poem describing a historical event. Often the person consults an interpreter – usually an older man – whose role is to explain the meaning of the poem in a way that he feels is helpful to the supplicant.

In one example, a young man asked whether it was 'blessed' for him to change his job (Hsu 1976). The interpreter read to him the *chien* poem on the paper he had drawn and then asked several questions before he made any interpretation, including how long he had been in the present job, why he was thinking of changing his job, and whether he had any opportunities for a new job. The young man replied that he had been in his present job for only a month or so, having just graduated from school. He did not like the job because of its long hours and low pay. He had made no plans for a new job and had no idea how to go about it. Upon hearing this, the interpreter said that it was not 'blessed' for the young man to change his job at that time, that young people should make more effort than demands, and that if he worked hard and long enough he would eventually be paid more.

Hsu (1976) suggests that *chien* fulfils a number of important therapeutic functions: giving hope, eliminating anxiety, strengthening self-esteem, and reinforcing adaptive social behaviour. Hsu suggests that *chien* counselling is particularly appropriate in the Chinese cultural milieu, in which deference to authority is highly valued, and in which it is considered rude to express emotion in a direct fashion.

### *Healing lament in Finland*

In Finland, there is a long and complex Christian faith tradition, allied to a powerful cultural theme of loss and abandonment, reinforced in modern times by experiences of Russian invasion and war. Contemporary Finland is also a society that supports different forms of psychotherapy, alongside a willingness to engage in therapeutic innovation. These strands of cultural life have come together in the revival of the practice of 'healing lament' (*Hoitava Itku*), especially as promoted by an organisation known as 'Those Who Cry With Words' (*Äi-Lamenters*) (Wilce 2011). Weekend workshops are offered, at which participants are trained in crying with words and melody. The majority of those

who attend are middle-class women, many of them with professional backgrounds in psychotherapy and healthcare. They report that the experience of learning to lament is ‘therapeutic’. They describe entering a trance-like state in which they can express themselves in an authentic way, with a positive and meaningful effect on their life as a whole.

### *Naikan therapy in Japan*

The form of therapy known as *Naikan therapy* reflects a distinctively Japanese integration of Western therapeutic practices and traditional Buddhist beliefs and rituals (Reynolds 1980, 1981a; Tanaka-Mastsumi 2004). Naikan therapy – similar in many ways to Morita therapy (Reynolds 1989) – is particularly effective with individuals who are depressed and socially isolated. The person spends several days in a retreat centre, engaging in a process of continuous meditation based upon highly structured instruction in self-observation and self-reflection. The role of the ‘counsellor’ is merely to interview the person briefly every 90 minutes to check that they have been following the specified therapeutic procedure, which consists of recollecting and examining memories of the ‘care and benevolence’ that the person has received from particular people at particular times in their life. Having recalled such memories, the client is then encouraged to move on to recollect and examine their memories of what they have *returned* or given to that person, and the troubles and worries that they have given that person. These questions provide a foundation for reflecting on relationships with others such as parents, friends, teachers, siblings, work associates, children, and partners. The person can reflect their self in relation to pets, or even objects such as cars and pianos. In each case, the aim is to search for a more realistic view of their conduct, and the give-and-take which has occurred in the relationship.

The most common result of this therapeutic procedure is an improvement in the person’s relationships, and an alleviation of levels of depression. Murase (1976) suggests that Naikan is effective because Buddhist philosophy (which represents a deeply held core dimension of a Japanese worldview) teaches that human beings receive ‘unmeasured benevolence’ from others and become troubled in life if they do not acknowledge this truth. In addition, elders are respected in Japanese culture to an extent that is not found in contemporary European cultures – to revisit the ‘care and benevolence’ of elders can be, for people who have grown up within Japanese culture, an antidote to depression and hopelessness.

### *Maori philosophy of life*

As in many traditional cultures, the New Zealand Maori people are deeply connected both to the land and to their family and community. This is expressed through a philosophy of life that emphasises a spiritual dimension (*taha wairua*) that reflects the inter-connection of living people, ancestors, and the natural environment. There are also dimensions that acknowledge the importance of thoughts and feelings (*taha hinengaro*), physical well-being (*taha tinana*), and family/social well-being (*taha whanau*) (McRobie and Agee 2017). All four dimensions, taken together, need to be taken into account when dealing with a problem in living. These concepts are also materially expressed in the design and layout of a *marae*, or tribal meeting place. The rituals through which people enter a *marae*, and then interact and speak within it, similarly embody the Maori core philosophy. Taken together, these elements create a highly meaningful and sacred space within which problems can be resolved and healing can take place (Durie 2007, 2011).

### *Native American sweat lodge ceremonies*

Healing ceremonies in which members of a community sit in close proximity inside a heated tent or building, and engage in rituals that involved sharing, darkness, and sweating, have been identified in many cultures. In Native American culture, this type of practice takes the form of a *sweat lodge* (Garrett et al. 2011). A lodge is a small, low structure, next to a river or lake. Participants need to divest themselves of clothing and personal possessions, and crawl in on their hands and knees. What



happens once inside can vary, but may include periods of silence, prayer, the passing around of a ritual object such as a pipe, the singing of songs, and discussion. After the ceremony, participants wash in a nearby stream or other water source, and talk. All of the activities are embedded in a set of values and belief system in which all aspects of the sweat lodge experience have meaning.

## Implications of culturally diverse healing practices

These examples of emotional healing practices in various cultures offer a perspective from which Western counselling, psychotherapy, and psychiatry can be evaluated. Driving to see a therapist once a week, sitting in an office and talking for an hour, then driving home. A 15-minute conversation with a psychiatrist every three months, followed by a repeat prescription of antidepressant medication collected from a pharmacist. These ways of healing, which are the norm in contemporary industrial societies, lack the holistic, collectivist, embodied, deeply meaningful processes that are central aspects of traditional healing practices. It is possible to recognise most of the types of therapy described in other chapters of this book as seriously culturally impoverished ways of doing things. In most European countries, traditional healing rituals of the kind described above have either been lost or have been marginalised.

It is not surprising, then, that a crucial area of competence for culturally sensitive therapists lies in being able to draw on therapeutic techniques and ideas that exist within the cultural world of the client, and integrate these resources into work with the client. The vignettes presented above offer examples of healing practices in the context of a specific cultural milieu. Many more examples could have been added. Further analysis and discussion of the use of indigenous healing resources can be found in many places, including Lee (2002), Moodley and West (2005), Pomerville et al. (2016), and Walter (1996).

### Box 23.1: The significance of language

The role of language, as a means of communicating meaning and significance, is of enormous importance in any therapy where therapist and client have grown up in different language communities. The language that a person acquired during their childhood is likely to be the most immediately accessible way in which a person can simply and directly convey the emotional truth of their life.

Bowker and Richards (2004) interviewed therapists about their experience of working with bilingual clients who were receiving counselling in their second language. A central theme in the accounts of these therapists was a sense of emotional distance from these clients, and uncertainty about whether they were truly understanding all of what the clients were telling them. Some of the therapists described cases in which clients had purposefully chosen to receive therapy in a second language, as a way of maintaining their own psychological distance from painful memories.

The role of language is even more acute in counselling with refugee or immigrant clients who require the involvement of an interpreter. The use of an interpreter brings another person into the counselling relationship, and the personal style and attitudes of the interpreter, and the extent to which both client and therapist trust the interpreter, become critical factors in determining the effectiveness of the therapy. There has been a considerable amount of research into the experience of using interpreters in therapy (see, for example, Lambert and Alhassoon 2015; K. E. Miller et al. 2005; Pugh and Vetere 2009; Raval and Smith 2003; Schweitzer et al. 2013). It is clear that there are marked differences between therapists in the way they work with interpreters. Some therapists view the interpreter as merely a translation machine, and are eager to dispense with the services of the interpreter at the earliest opportunity. For other therapists, the



interpreter becomes a central participant in the therapeutic process, a witness to the client's story and a cultural consultant.

A similarly complex and nuanced picture emerges from studies where either the client or therapist (or both) is using a second language (Costa and Dewaele 2014; Espín 2013; Ivers et al. 2013; Rojas et al. 2014; Rolland et al. 2017). For example, at certain moments the speaker may shift from one language to another, reflecting the topic being explored or as an expression of their emotional state. Whether therapy works or not in such circumstances seems to depend on the experiences, willingness, and imagination of each participant, and the specific institutional setting within which they are meeting.

## Cultural identity and intersectionality

A key challenge for any therapist committed to a culturally sensitive approach to practice is to gain a clear understanding of the cultural identity of each client with whom they are working. An understanding of the complexity of cultural identity (including one's own identity) represents a core area of competence in relation to culturally sensitive practice.

Individuals differ in the degree to which they have developed an awareness of their cultural identity – some people have never reflected on their cultural roots, whereas others have devoted a great deal of time and effort to exploring such issues. Models of cultural identity development have been constructed by Helms (1995), Sue and Sue (2003), and others; a good summary of recent developments can be found in Ibrahim and Heuer (2016). A key facet of cultural identity models is that they describe different processes of development for people in dominant and subordinate cultural groups, respectively. At the first phase of cultural identity development, a person has limited awareness of themselves as a cultural being. At later phases, experiences of meeting people from different cultural backgrounds trigger an increasing awareness of cultural factors. For a person in a subordinate cultural group, this phase is characterised by increased identification with their own group, and a strong rejection of the values and worldview of the dominant group. For a member of a dominant cultural group, this phase is accompanied by guilt and questioning of their privileged position, and denigration of aspects of their own culture. At a final phase of cultural identity development, subordinate and dominant cultural group members are able to achieve a more balanced and nuanced view of the role of cultural factors in their lives. They become able to sustain meaningful and satisfying relationships with members of other cultural groups, and to appreciate the wider historical and socio-political factors that shape intergroup conflict, stereotyping, and ignorance. This model has significant implications for therapy practice. For example, the relevance and impact of cultural differences between client and therapist will vary a great deal depending on the stage of cultural identity development at which each participant is currently functioning.

The concept of *acculturation* is also relevant in such situations (Ibrahim and Heuer 2016). Acculturation refers to the way that people from outside a dominant culture, such as migrants, refugees, and exiles, gradually learn about and assimilate the norms and beliefs of the new culture.

The identities of most people in modern societies derive from multiple cultural sources – a grandmother who was Irish, a grandfather who was Jamaican, an interest in Buddhism acquired in adulthood (see, for example, Josephs 2002; Ramirez 1991). In recent years, the concept of *intersectionality* has been used as a way of moving beyond broad categories such as Black, Asian British, or Irish, and of developing a more differentiated understanding of the ways in which inequality is comprised of multiple overlapping identities that intersect with the multiple identities of others (Moradi and Grzanka 2017). An example of how intersectionality opens up new ways of making sense of therapeutic work can be found in a focus group study carried out with Black and Hispanic therapist social workers in the USA (Greenberg et al. 2018). Analysis of practitioner accounts of their work revealed complex, shifting identity negotiations that took place between them and their clients. Another

example of the application of an intersectionality perspective is available in a series of studies into the resilience strategies of sexually abused women, which sought to go beyond existing models of survival and recovery by exploring experiences of women in specific ethnic communities (Collins et al. 2014; Singh et al. 2013).

Intersectionality is a potentially valuable construct for therapists interested in culturally oriented practice, because it makes it possible to get closer to the unique combination of identities and values exhibited by individual clients. Scholarship and research around intersectionality has a specific focus on institutional sources of disadvantage, rather than adopting a purely psychological or individualist perspective, thereby allowing connections to be made with a social justice approach to therapy (see Chapter 26).

### **Box 23.2: Qualitative research into the experience of cross-cultural therapy**

Qualitative studies of client and therapist experiences provide participants with an opportunity to share what therapy was like for them. Such an approach to research has the advantage of being open to all aspects of a phenomenon, rather than focusing on specific factors. Interview-based research on cultural minority clients being seen by white therapists consistently describe a therapeutic process characterised by difficulty in establishing common ground (Chang and Berk 2009; Chang and Yoon 2011; Earl et al. 2011; Ward 2005). One study carried out in the UK that involved interviews with both clients and their therapists provides a particularly vivid account of awkward therapeutic conversations in which both parties avoided talking about race or culture (Dos Santos and Dallos 2012). The overall message from these studies is that although therapy in the context of cultural difference can be helpful and effective, there are also many ways in which it can go wrong, and that a good outcome depends on personal commitment and openness on the part of both client and therapist.

## **Culturally sensitive therapy in action**

So far, we have mainly considered the question of how to make sense of culture, and how to develop an appreciation of how the way that a person experiences the world is built up through a multiplicity of cultural influences. We now turn to a discussion of how a multicultural approach can be applied in practice, in terms of the techniques and strategies that are distinctive to this approach.

### **General strategies**

Ramirez (1991) argued that the common theme running through all cross-cultural therapy is the challenge of living in a multicultural society. He proposed that a central aim in working with clients from all ethnic groups should be the development of 'cultural flexibility'. Ramirez (1991) pointed out that even members of a dominant, majority culture report the experience of 'feeling different', of a sense of mismatch between who we are and what other people expect from us. The approach advocated by Ramirez (1991) involves the therapist encouraging experimentation with different forms of cultural behaviour. Another general strategy in culturally sensitive therapy has been to focus on the links between personal problems and political/social realities. For example, in her powerful and influential writing on this topic, Holland (1990) made a distinction between loss and expropriation. Individuals in cultural minority groups do not merely experience loss, such as the loss of a family member or of a job. Instead, they experience expropriation – things have been taken away from them, often through the use of actual or threatened violence. Although Holland (1990) worked with

working-class black women in Britain, the experience of having core life opportunities stolen by powerful others is a common theme in the lives of those who are gay, lesbian, religiously different, unemployed, or sexually abused. Loss can be addressed and healed through therapy, but expropriation can only be remedied through social action. The theme of empowerment, within an individual life, through self-help groups or by political involvement, needs to be kept in the frame as a distinctive and essential ingredient of culturally sensitive therapy. There can be an unconscious dimension to the links between personal problems and socio-historical realities, as in the form of internalised racism (Kareem 2000). A further strategy, widely applied in contemporary practice, is to find ways of adapting established models of therapy so that they align with the beliefs and values of service users from 'minority' groups or from cultural backgrounds that are different from those of the therapist or the person/group who developed the model in the first place.

### Box 23.3: Working with the client's explanatory model

The psychiatrist and social anthropologist Arthur Kleinman is one of the leading figures in the area of cross-cultural mental health (Kleinman 2004). His book *The Illness Narratives: Suffering, Healing and the Human Condition* (Kleinman 1988) is a classic within this field. One of the central themes in Kleinman's work has been to help health professionals to appreciate the very different ways in which people from different cultural groups make sense of illness and health. He suggests that it is essential for any helper to make the effort to understand the client's or patient's 'explanatory model' (Kleinman 1988; Kleinman and Benson 2006) by collecting information in relation to the following questions:

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take? How serious is it?
- What do you think that this problem is doing to your body and mind?
- What do you most fear about this condition?
- What do you most fear about the treatment?

Such questions open up an appreciation of 'what matters most' for the client, and enables the therapist to use their expert knowledge alongside that of the person seeking help.

### Cultural curiosity and humility

Dyche and Zayas argue that in practice it is impossible for counsellors and psychotherapists to enter the first session with comprehensive detailed knowledge of the cultural background of their client. They suggest, moreover, that any attempt to compile such knowledge runs the danger of arriving at an over-theoretical, intellectualised understanding of the culture of a client, and may risk 'seeing clients as their culture, not as themselves' (1995: 389). Dyche and Zayas argue that it is more helpful to adopt an attitude of cultural naiveté and respectful curiosity, with the goal of working collaboratively with each client to create an understanding of what their cultural background means to them as an individual. Ridley and Lingle (1996) refer to a similar stance towards the client, but discuss it in terms of *cultural empathy*. David and Erickson (1990) argue that this quality of curiosity about, or empathy towards, the cultural world of others must be built upon a similar attitude towards one's own culture. Hook et al. (2013) developed a brief scale for clients to rate the 'cultural humility' of their therapist; sample items included 'my therapist is open to seeing things from my perspective' and 'my therapist thinks he/she understands more than he/she actually does'. In an

exploratory study, Hook et al. (2013) found that clients who perceived their therapist as exhibiting cultural humility were more likely to improve than those who held the opposite view.

These various sources of clinical and research evidence reinforce the point that the practice of culturally sensitive therapy depends on an underlying attitude or value position, characterised by curiosity, humility, and a collaborative style, as much as it does on specific techniques and theories.

### **Box 23.4: The challenge of being a therapist from a cultural minority group**

The counselling and psychotherapy professional community remains dominated by practitioners, trainers, and academics from white majority cultural backgrounds. Various studies have described the challenges associated with being a student/trainee from a minority cultural group (Baker et al. 2015; Haskins et al. 2013; Hipolito-Delgado et al. 2017; McKenzie-Mavinga 2005) and then practising as a therapist (Odusanya et al. 2018). The under-representation of people with black and ethnic minority identities inhibits the development of culturally sensitive approaches to therapy, and acts as a barrier to accessing therapy in members of these communities.

### **Broaching: initiating conversations about cultural issues**

One specific therapist behaviour or skill that can be observed in effective culturally sensitive therapy is 'broaching' – taking the initiative in talking about sociocultural issues (Day-Vines et al. 2007). Moodley (1998) has used the phrase 'frank talking' to describe this kind of therapist openness to cultural issues. Evidence for the significance of this skill is based on a substantial programme of research. Thompson and Jenal (1994) carried out a study of the impact on the counselling process of counsellor 'race-avoidant' interventions. In other words, when working with clients who raised concerns about race and culture, these counsellors responded in ways that addressed only those aspects of the client's issue that could relate to anyone, irrespective of race, rather than acknowledging the actual racial content of what was being said. Thompson and Jenal (1994) found that this kind of 'race neutralising' response had the effect of disrupting or constricting the client's flow, and led either to signs of exasperation or to the client conceding or deferring to the counsellor's definition of the situation by dropping any mention of racial issues. Similar findings have been reported by Lee and Bhuyan (2013), Lee and Horvath (2014), Moodley et al. (2004), Owen et al. (2011), Tsang et al. (2011), and Tuckwell (2001). In their analysis of how therapists manage broaching conversations, Bayne and Branco (2018) found that practitioners were generally uncomfortable in such situations, took account of the impact on the client and the therapy, and employed both direct and indirect strategies for initiating such conversations. Day-Vines et al. (2013) have developed a questionnaire measure of various aspects of the skill of broaching.

In recent research, Owen et al. (2017) found that therapists who were not comfortable talking about cultural issues recorded a higher drop-out rate among ethnic minority clients, and Drinane et al. (2018) observed that therapist concealment of sociocultural identity information (i.e. the opposite of broaching) was associated with poorer client outcomes. In another study, Thompson and Alexander (2006) found no differences in process or outcome measures between clients who had worked with a 'race-avoidant' counsellor and those whose counsellor actively invited conversation around racial and ethnic issues.

The process of broaching is complex (Bayne and Branco 2018) and needs to be handled sensitively. Cardemil and Battle (2003) suggested that some clients may not like it if their therapist insists on talking about cultural matters, when what they want to do is to talk about personal concerns.

From within the person-centred tradition, Patterson (2004) argued that it is not helpful for therapists to pay attention to issues of cultural difference in their conversations with clients, because this distracts from their capacity to respond to the client as a person. Nevertheless, there is a broad consensus across the profession that it is necessary for counsellors and psychotherapists to take the initiative in acknowledging and giving voice to possible areas of difference in cultural worldview and experience that may have a bearing on the therapeutic process and relationship. Day-Vines et al. (2018) have developed training materials and activities to facilitate student learning in this area.



### Case study 23.1: A culturally sensitive approach to counselling in a case of traumatic bereavement

In the winter of 1984, about 12,000 *Falashas* (Jews of Ethiopia) were driven out of their villages in northern Ethiopia by a combination of hunger, fear of war, and a desire to emigrate to Israel. On their long march through the desert and in refugee camps about 3,000 died. Eventually, the Israeli government managed to airlift the survivors to safety, but only after enormous trauma and disruption to family groups. Some two years later, M, a 31-year-old Ethiopian woman, married with four children, and who spoke only Amharic, was referred to a psychiatric unit in Jerusalem. Although it was difficult to obtain adequate translation facilities, it emerged that she had wandered for many weeks in the desert, during which time her baby had died. She continued to carry the dead body for several days, until she arrived in Israel, when the strong-smelling corpse was taken from her and buried. For the previous two years, she had been repeatedly hospitalised following 'asthmatic attacks'. Now she was agitated, fearful, and depressed, and complained of 'having a snake in her leg'. She was diagnosed as suffering from an acute psychotic episode. The staff in the psychiatric unit were able to find an anthropologist familiar with M's culture and language, and it emerged that she experienced herself as 'impure' because she had never been able to undergo the purification ritual required by her religious sect for all those who have come into contact with a human corpse. Her mother-in-law had not allowed her to talk about her feelings surrounding her bereavement: 'snake in the leg' turned out to be a Falasha idiom for referring to disagreement with a mother-in-law. M received counselling that encouraged her to talk about the death of her baby, and a purification ritual was arranged. At 30-month follow-up, she was doing well and had a new baby, although she admitted to still mourning her dead child.

The case of M, and the issues it raises, are described more fully in Schreiber (1995). It is a case that demonstrates the strengths of a culturally informed approach to psychotherapy. Although the person in need presented with physical, somatic symptoms that could in principle be treated by medication and conventional Western psychiatry, the therapists involved in the case took the trouble to explore the *meaning* of these symptoms, and then to construct a form of help that brought together indigenous and psychotherapeutic interventions in a way that was appropriate for this individual person.

## Ethnic/cultural client–therapist matching

Although cultural issues continue to be significantly under-represented in the psychotherapy research literature (Delgado-Romero et al. 2005), a topic that has received considerable attention has been the question of client–therapist ethnic matching: do clients benefit more from seeing a counsellor or psychotherapist with a similar ethnic background to their own?

Findings from some studies suggest that black clients seeking help from 'majority culture' agencies will drop out of treatment more quickly than white clients (Sattler 1977). Thompson and



Alexander (2006) found that African American clients assigned to an African American therapist reported more perceived benefit than those who had been allocated to a European American counsellor. There is also evidence that in these situations black clients receive more severe diagnostic labels and are more likely than white clients to be offered drug treatment rather than therapy, or to be referred to a non-professional counsellor rather than a professional one (Atkinson 1985).

Research has shown that clients tend to prefer therapists from the same ethnic group and view them as being more competent (Cabral and Smith 2011; Swift et al. 2015). Better results also appear to be associated with culturally matched client–therapist dyads. For example, in one study, Sue et al. (1991) checked the client files of 600,000 users of therapy services from the Los Angeles County Department of Mental Health between 1973 and 1988. Ethnic match between client and therapist was strongly associated with length of stay in treatment (i.e. fewer early drop-outs). For those clients whose primary language was not English, ethnic match was also associated with a better therapy outcome.

However, the effect of client–therapist ethnic matching is not straightforward. Shin et al. (2005) carried out a systematic review of ten ethnic matching studies that had used samples of African American and European American counsellors and clients in the USA. This review found that, overall, there were no differences between ethnically matched and unmatched client–therapist dyads in terms of attrition (dropping out of therapy early), total number of sessions, or overall outcome. However, Shin et al. (2005) noted that there were significant methodological limitations in the studies that they identified, particularly around providing information on the basis on which matching was carried out. Also, there were wide differences in the findings reported by the studies included in their review, with some studies showing that matched clients did better, and other studies showing that there was more benefit for unmatched clients.

Research and reviews by Farsimadan et al. (2007, 2011) have found that ethnic matching is associated with a stronger therapeutic alliance and outcomes, whereas mismatch tends to lead to a poorer alliance and less satisfactory outcomes. It seems likely that the somewhat ambiguous results of studies of ethnic matching can be explained in terms of counsellor and psychotherapist multicultural competence. Owen et al. (2012) and Imel et al. (2011) carried out research into the outcomes of therapy in which therapists saw some clients with similar ethnic backgrounds to their own and other clients with different ethnic backgrounds. Overall, there was a tendency for therapists, as a group, to do better with clients who were culturally similar to them. However, in both studies there were big differences in the cross-cultural effectiveness of individual therapists. Some of the therapists in these studies were equally effective with matched and non-matched clients, whereas others only appeared to be able to work effectively with matched clients. These findings suggest that the mixed results in ethnic matching research may be attributable to the proportion of culturally competent therapists included in the study: if most of the therapists in a study are culturally competent, the ‘matching effect’ disappears. It is important to note, in this context, that in the studies of both Owen et al. (2012) and Imel et al. (2011), it was possible to differentiate between general counselling competence and specific cultural competence.

The complexities of cultural matching were further explored in a study by Ibaraki and Hall (2014). In an analysis of almost 5,000 cases from a university counselling centre, they found that ethnic matching had a strong and consistent impact on client retention – clients were much more likely to stay in therapy if they had been allocated to a therapist from a similar cultural background to their own. However, the actual process of counselling was influenced by ethnic matching in subtle ways, which appeared to be influenced by cultural norms. For example, African American clients were more likely to discuss substance use when paired with an ethnically matched therapist, but Asian American clients were significantly less likely to do so.

The research studies mentioned so far examined client–therapist ethnic/cultural matching through the use of quantitative and statistical methods, across large samples. An alternative approach involves conducting in-depth interviews with clients and therapists, around their personal experience of therapy in cases of cultural difference. A number of studies of client and therapist



experiences of doing or receiving counselling with a person from a different cultural background have been published (Chang and Berk 2009; Chang and Yoon 2011; Thompson et al. 2004; Ward 2005). In these studies, ethnic minority clients consistently reported that they believed that therapy could potentially be valuable for them, but believed that there were barriers to accessing therapy services, and that therapists were insensitive to their experience. Barreto (2013) and Burkard et al. (2006) interviewed therapists about their experience of working with clients from different cultural backgrounds and found that, for these practitioners, while this work was challenging, it was also satisfying, and that being open about differences appeared to be an effective strategy for building a constructive therapeutic relationship.

Looking at the evidence as a whole for client–therapist cultural matching, it is clear that in some instances matching is helpful in relation to the process and outcome, and sometimes it does not appear to make any difference one way or the other. With the partial exception of a study by Dhillon and Ubhi (2003), there does not appear to be any evidence of client–therapist matching having a negative effect. Although it is not hard to imagine cases where matching could be experienced by clients as inhibiting their involvement in therapy, this phenomenon has not been highlighted to any extent in the research that has been carried out. This body of research would appear to support two main conclusions. First, it is necessary to offer clients a choice in relation to the cultural/ethnic background of their therapist. Second, culturally specific counselling agencies and therapy clinics represent a valuable resource for those individuals for whom cultural identity and/or religious faith is highly significant, because they can be sure that they will get a therapist who shares their worldview.

### **Box 23.5: How relevant are Western ideas about therapy to people living in Islamic societies?**

In many predominantly Islamic societies, such as Saudi Arabia, Kuwait, Qatar, and Malaysia, counselling and psychotherapy have become an accepted component of health and social services provision (Al-Issa 2000a). In these countries, exposure to Western ideas through trade, education, travel, and the global media has resulted in the adoption of ideas about counselling and psychotherapy taken from Europe and North America.

Al-Issa (2000b) points out that there exists a rich history of Islamic psychiatry and psychotherapy, which pre-dates Western psychiatry, and which in general is more accepting of abnormal behaviour than its Western equivalent. As a result, therapy clients who have a Muslim cultural identity will bring into counselling distinct images and expectations regarding the role of the healer and process of help.

Al-Abdul-Jabbar and Al-Issa (2000) suggest that ‘insight-oriented’ approaches to therapy, and therapy that involves questioning parental values and behaviour, may be hard to accept for many Islamic clients brought up in a strongly patriarchal culture. They offer a case history of Nawal, a 28-year-old married woman who complained of being constantly anxious and losing control of her emotions. In therapy, Nawal disclosed that she had entered into an affair with another man and was feeling guilty about it. The therapist used mainly open-ended questions to help the client to explore and reflect on her feelings and choices in this situation. However, her symptoms deteriorated the longer therapy continued. Al-Abdul-Jabbar and Al-Issa (2000) reported that at that point, it became necessary to use direct guidance, based in Islamic teachings. They suggest that non-Muslim counsellors working with Muslim clients need to be aware of the importance of religious and collective values, and of Muslim language, imagery, and metaphor, for clients from this background. They emphasise that the role of the therapist must involve a willingness to be

assertive, direct, and advisory: being 'teacher-based' rather than 'student-based'. The counsellor should also be able to express their own emotions and to console the client. Finally, the counsellor should remember that the client is seeking to find solutions that strengthen their interdependence with other family members, rather than promoting independence and self-actualisation.

There exists a substantial literature on the use and adaptation of models of counselling and psychotherapy for Muslim clients (see, for example, Abu-Raiya 2015; Dwairy 2009; Kizilhan 2014; Mir et al. 2015; Raiya and Pargament 2010; Weatherhead and Daiches 2010). However, to date, research studies have not unambiguously established the effectiveness of culturally adapted therapies for Muslim clients (Anderson et al. 2015; Mir et al. 2015; Walpole et al. 2013). This may be because, taken as a whole, the development of Islamic therapy is perhaps best seen not as an instance of the straightforward application of Western ideas in a different cultural context, but as an instance of active appropriation by Muslim individuals and groups of an approach to helping that they have assimilated into their way of life – and have made their own (Al-Issa 2000a; Haque et al. 2016). It is possible, therefore, that standard outcome measures may not be appropriate to capture the meaning of therapy for such clients.

## Adapting or developing services and agencies to meet the needs of client groups from different cultures

To meet the needs of disadvantaged or culturally diverse clients, counsellors and psychotherapists need to look at the structure, staffing, and operation of their agencies, and how welcoming they are to clients who may be concerned about not fitting in. Rogler et al. (1987) and Gutierrez (1992) described a range of organisational strategies that have been adopted by counselling and therapy agencies to meet the needs of ethnic minority clients, but which are also applicable in other contexts. One approach they describe focuses on the question of access. There are many factors (financial, geographical, attitudinal) that prevent people from seeking help. Agencies can overcome these barriers by publicising their services differently, employing outreach workers, hiring bilingual or bicultural staff, opening offices at more accessible sites, and providing crèche facilities. A second level of organisational adaptation involves tailoring the counselling or psychotherapy to the target client group. Services are modified to reflect the issues and problems experienced by a particular set of clients. One way of doing this is to offer courses or groups that are open to these people only, such as a bereavement group for older women, an assertiveness class for carers, or a counselling programme for women with drink problems.

A simple example of cultural adaptation of a standard therapeutic intervention (relaxation for anxiety) can be found in La Roche et al. (2011). This study was based on the realisation that, for members of a Latino community in the USA, culturally individualist imagery accompanying relaxation (for example, 'imagine yourself on a beautiful beach') was less effective than imagery that represented collectivist values (for example, 'imagine yourself surrounded by loved ones'). In a more complex cultural adaptation, Rogler et al. (1987) describe the invention of *cuento*, or folklore therapy, as a therapeutic intervention specifically designed to be of relevance to a disadvantaged group, in this case disturbed Hispanic children. This approach is based on cognitive-behavioural ideas about modelling appropriate behaviour, but the modelling is carried out through the telling of Puerto Rican folktales, followed up by discussion and role-play. A paper by Le et al. (2010) explains the procedures followed by one therapy centre to develop a culturally informed version of a well-established CBT therapy model for use with clients from a minority cultural group. Many other examples exist that demonstrate the effectiveness of the strategy of cultural adaptation of therapeutic approaches and techniques. There is strong evidence that culturally adapted therapy tends to be well received by clients, reduces drop-out, and leads to better final outcomes (Benish et al. 2011; Hall et al. 2016).

A further stage in the adaptation of a counselling or psychotherapy agency to the needs of minority or culturally diverse clients relates to when the actual structure, philosophy, or aims of the organisation are changed as a response to it seeing more and more members of formerly excluded groups. When this happens, initiatives of the type described before can no longer be marginal to the functioning of the organisation, but come to be seen as core activities.

Another strategy that has been adopted in order to make therapy available to 'minority' clients has been to set up specialist agencies that appeal to specific disadvantaged groups. A wide array of agencies have developed to provide counselling to women, people from different ethnic and religious communities, gay and lesbian people, and so on. These services are based on the recognition that many people will choose to see a counsellor who is similar to them. One of the difficulties these agencies face is that, usually, they are small and experience recurring funding crises. They may also find it difficult to afford training and supervision. Nevertheless, there is plentiful evidence that people who identify strongly with a particular set of cultural experiences often do choose to consult counsellors and psychotherapists who share these experiences. On these grounds, it can be argued that it is vitally important to maintain a diversity of counselling provision, and to find ways of encouraging the development of effective specialist agencies. A study by Netto et al. (2001; Netto 2006), based in the Asian community in the UK, found that their informants reported many barriers to access to counselling agencies. The authors compiled a list of recommendations of strategies that agencies might employ to enhance access for Asian clients.

There are several examples of counselling agencies having carefully planned and designed their services to reflect the needs of the culturally diverse communities that they serve. For instance, the Just Therapy Team in New Zealand has developed a form of practice that is consistent with the separate and interlocking strands of Maori, Samoan, and European culture within that society (Tamasese and Waldegrave 1990; Waldegrave et al. 2003). The My Time counselling service in Birmingham, UK, is an example of a highly successful counselling practice that has developed in response to the needs of a multi-ethnic community (Lilley 2007; Lilley et al. 2005). The key to the success of both Just Therapy and My Time has been the creation of culturally diverse staff teams offering a range of services that encompass not only counselling/psychotherapy but also practical forms of help. In addition, both of these agencies have carefully considered the theoretical basis of their work, and have developed theoretically integrative approaches that are appropriate both to their client populations and service goals.

### Box 23.6: Microaggression – the invisible dynamics of cultural difference

An important research-based development in culturally sensitive theory and practice in recent years has focused on the phenomenon of *microaggression*: 'brief and commonplace daily verbal, behavioural, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color' (Sue et al. 2007: 271). Three forms of microaggression can be identified: *micro-assault* (use of racist language or active discrimination against members of ethnic minority groups), *micro-insult* (example: a minority employee is asked 'how did you get that job?'), and *micro-invalidating* (nullifying the reality of the target person, for example by telling them they have over-reacted if they comment on having been subjected to negative attitudes).

Sue et al. (2008) suggest that members of low-status cultural groups are exposed to excluding and wounding responses on an everyday basis in ways that are largely outside of conscious awareness. The implication for counselling and psychotherapy is that this kind of interaction can occur within therapy sessions, and that therapists may not be aware that it is happening.

And there is a growing body of evidence that microaggression undermines the establishment of a productive and trusting therapeutic relationship (Davis et al. 2016; Hook et al. 2016; Houshmand et al. 2017; Owen et al. 2014; Rogers-Sirin et al. 2015).

To counteract microaggression, therapists need to examine not only their attitudes and knowledge around cultural issues, but also the subtle ways in which they interact with people from different cultural groups. The existence of subtle microaggressive interactions makes it possible to make sense of why it is hard to define how and why cross-cultural counselling can go wrong, and why it is hard for counsellors to fix things. The concept of microaggression draws attention to the fact that difficulties in cross-cultural interaction are not so much a question of *difference* but of *status*. It is not that one person just does not understand the other person. What is happening, instead, is that they implicitly believe that they are superior to the other. Microaggression occurs not only in situations of ethnic or cultural difference, but also in situations where differences are defined by gender, age, disability status, sexual orientation, and other dimensions. The concept of microaggression has become a topic for passionate debate (Sue 2017), following publication of a controversial article by Lilienfeld (2017) that argued that the evidence for, and impact of, microaggression had been overstated.

## Guidelines and competencies

Multicultural counselling and psychotherapy can take many forms. In responding to the needs and experiences of people from different cultural backgrounds, a multicultural therapist or therapy agency needs to be creative and adaptive. Drawing on the culture and therapy literature as a whole, and in particular the work of La Roche (2005; La Roche and Maxie 2003), it is possible to identify some broad guidelines for culturally sensitive practice:

- 1 There is no single concept of 'normal' that applies across all persons, situations, and cultures. Mainstream concepts of mental health and illness must be expanded to incorporate religious and spiritual elements. It is important to take a flexible and respectful approach to other therapeutic values, beliefs, and traditions: we must each of us assume that our own view is to some extent culturally biased.
- 2 Individualism is not the only way to view human behaviour and must be supplemented by collectivism in some situations. Dependency is not a bad characteristic in all cultures.
- 3 It is essential to acknowledge the reality of racism and discrimination in the lives of clients, and in the therapy process. Power imbalances between therapist and client may reflect the imbalance of power between the cultural communities to which they belong.
- 4 Language use is important – abstract 'middle-class' psychotherapeutic discourse may not be understood by people coming from other cultures. Linear thinking/storytelling is not universal.
- 5 It is important to take account of the structures within the client's community that serve to strengthen and support the client: natural support systems are important to the individual. For some clients, traditional healing methods may be more effective than Western forms of therapy.
- 6 It is necessary to take history into account when making sense of current experience. The way that someone feels is not only a response to what is happening now, but may be in part a response to loss or trauma that occurred in earlier generations.
- 7 Be willing to talk about cultural and racial issues and differences in the therapy room. Be actively curious about the social and cultural world in which the client lives their life, and their cultural identity.

- 8 Check it out with the client – be open to learning from the client.
- 9 Take time to explore and reflect on your own cultural identity, and associated attitudes and beliefs, and how these shape your interaction with clients.

These principles have informed, and have been incorporated into, the construction of lists of multi-cultural therapy competences and the design of training programmes (Bager-Charleson et al. 2017; Chu et al. 2016; Day-Vines et al. 2018; Fawcett and Evans 2013; Sadowsky et al. 1994, 1998; Sue and Sue 2007; Tummala-Narra 2015; Tummala-Narra et al. 2017; Worthington et al. 2007).

### Box 23.7: Taking account of cultural wealth

The notion of 'cultural wealth' refers to the life-enhancing skills and knowledge that exists within what may be perceived as deprived communities (Walck 2017). This perspective can inform therapy in many ways, such as through the therapeutic use of genres of popular music (Washington 2018), as well as creative engagement with many other resources, support networks, and collective memories within the particular social networks within which a client might reside.

## Conclusions

The cultural dimension of therapy is important. There has been a considerable amount of research into the impact of adapting counselling and psychotherapy services and procedures for cultural minority clients. Reviews of this literature by Benish et al. (2011) and Hall et al. (2016) have concluded that culturally adapted therapy is significantly more effective than standard therapy for clients from minority backgrounds. Failure to take cultural identity seriously runs the risk of excluding a significant proportion of the population from therapeutic help. Key figures in the counselling and psychotherapy professions have argued that failure to adopt culturally sensitive and culturally adapted ways of working is harmful for clients – and is unethical (Sue 2015; Wendt et al. 2015).

At the same time, the field of culturally sensitive counselling and psychotherapy is fragmented and lacks a coherent theoretical basis. The reason for this is that culture is not a 'factor' that influences therapy in the way that length of therapy, client age, or motivation do. Instead, culture permeates all aspects of therapy. All of it is cultural – therapy is a cultural practice that exists within a cultural setting. It is not possible to separate it out, with therapy in one box and culture in another one. The validity of this position can be confirmed by reflecting on the structure of the present book. The selection of topics to be included in the present chapter – and not other chapters – is highly arbitrary. Topics such as religious faith and spirituality, social class, disability, the history of therapy, and much more clearly represent important dimensions of cultural life. Thirty years ago, Paul Pedersen, along with other psychologists and therapists, made a sustained effort to put culture at the heart of counselling and psychotherapy. It seems reasonable to conclude that their initiative remains an aspiration and work in progress. Contemporary therapy theory, practice, and research does little more than give a nod to culture, in the form of concepts such as culturally 'informed', 'adapted', 'sensitive', and 'responsive'. The espousal of an approach to counselling and psychotherapy that is genuinely grounded in cultural understanding remains a challenge to mainstream traditions in therapy, which persist in operating on the basis of a largely individualised and psychologised concept of the person, in which social and cultural factors are only of peripheral interest.



## Topics for reflection and discussion

- 1 It can be argued that mainstream approaches to counselling and psychotherapy (psychodynamic, person-centred, cognitive-behavioural) are so intrinsically bound up with Western assumptions about human nature that they are just not relevant to people from traditional, non-Western cultures. Do you agree?
- 2 How would you describe your own cultural identity? What stage of development have you attained in relation to your cultural identity? How does your cultural identity influence your involvement in therapy, as a therapist and/or a client?
- 3 Reflect on the way that counselling and psychotherapy agencies and services operate in your town or city. If appropriate, collect any leaflets that they use to advertise their services. How sensitive are these agencies to cultural diversity? What effect might their attitude to cultural issues have on the clients who use their services, and on the way they are perceived in the community?
- 4 Is racism the real issue? Is there a danger that term such as 'multicultural' and 'cultural responsiveness' might distract attention from the experiences of violence, oppression, and expropriation that are caused by the ideology of racism?
- 5 Identify a culture-bound syndrome that is of particular interest for you, either because you have had some contact with that culture or because you work with clients from that community. In what ways does the syndrome itself, and the indigenous therapies associated with it, reflect the beliefs and values of the culture within which they are embedded? In what ways does the study of this culture-bound syndrome enrich your understanding of the therapeutic process and relationship within your own cultural group and/or your own life?

## Suggested further reading

There are two textbooks that offer extended coverage of the themes introduced in this chapter and are highly recommended. The *Handbook of Transcultural Counselling and Psychotherapy*, edited by Colin Lago (2011), offers a mainly British perspective. The *Handbook of Multicultural Counseling*, edited by Joseph Ponterotto and colleagues (2010), includes mainly North American contributions. An accessible and stimulating, but also carefully referenced, exploration of the complex and troubled relationship between culture and mental health is *Crazy Like Us: The Globalization of the Western Psyche*, by Ethan Watters (2010). Fernando (2017) provides a critical analysis of the pervasiveness of institutional racism in mental healthcare.



# Chapter 24

## Therapy and the social

<b>Introduction</b>	<b>362</b>
<b>The social origins of personal problems</b>	<b>363</b>
<b>Conceptual frameworks for making sense of social disadvantage</b>	<b>364</b>
Social capital	365
Inequality	366
Weathering	366
Distancing	367
Place	367
<b>Social interventions</b>	<b>368</b>
Generic social repair processes	368
Constructing social solidarity: narrative therapy	368
Using therapy to undo the effect of social degradation and humiliation	368
Befriending	369
Social involvement initiatives	370
Social matrix dreaming	370
Prevention	371
<b>The significance of social class, social status, and poverty</b>	<b>372</b>
<b>The significance of affluence and privilege</b>	<b>374</b>
<b>Evaluating the social outcomes of therapy</b>	<b>374</b>
<b>Conclusions</b>	<b>374</b>
<b>Topics for reflection and discussion</b>	<b>375</b>
<b>Suggested further reading</b>	<b>375</b>

### Introduction

The theory and practice of counselling and psychotherapy has been dominated by a focus on the individual person. Problems are understood as having their origins in various types of dysfunction within the person, such as deficits in cognitive and emotional processing within the person, or the

development of a conflicted sense of self. In similar fashion, problems are alleviated through interventions that seek to bring about shifts in individual functioning, and the effectiveness of therapy is then evaluated in such terms. Behind all of this lies an appreciation that individuals exist within a culture and society. However, cultural and social factors are seldom central to the process of therapy. If they are addressed at all, it is mainly for the purpose of adapting or modifying standard psychological interventions to make them culturally meaningful and acceptable, or to adhere to societal requirements around cost and accessibility.

While acknowledging the relevance of psychological and neurobiological processes, it is possible to conduct therapy in a way that places a primary emphasis on the social causes of personal distress, and on social and cultural resources and activities as the means of overcoming such distress. The present chapter offers an introduction to what therapy looks like from a social perspective. The key distinctive feature of such a perspective is that it seeks to go beyond merely enabling individuals to acquire coping skills that will allow them to deal effectively with the stress of living in contemporary society. Instead, a truly socially oriented therapy has the aim of contributing to the building of a better society. Such an aim has not been part of the way that mainstream counselling and psychotherapy views its mission. However, the ideas and examples explored in the following sections describe many strategies through which such an objective can be pursued.

## The social origins of personal problems

A socially informed approach to therapy requires a capacity to make sense of the social causes that lie behind the problems that people take to therapy. It also requires a basis in research, to provide confidence that the influence of social factors is real and tangible. Because of the psychological and, increasingly, neuroscience emphasis of most mainstream psychotherapy research, relatively few studies have directly investigated the social processes occurring in the lives of therapy clients. On the other hand, many studies have looked at the influence of social factors on the development of mental health problems.

The idea that social factors, such as stress and life events, play a significant part in the development of mental health problems is widely accepted by most people (Read et al. 2010). However, the professional and research literature continues to be dominated by debates around the relative influence of biological/genetic and social processes in this area. It is widely argued that social causes of mental health problems are in fact not all that important, because genetic differences, such as differences in personality and psychological functioning, mean that people differ in their vulnerability to social stressors. From a social perspective, there are three main responses to such efforts to underplay the impact of social events. First, whether or not someone possesses a high level of resilience, the negative social event or process has still occurred and demands to be taken into account. Second, it is necessary to be critical and questioning when interpreting evidence from biological and genetic studies, which have consistently overstated the evidence for biological and genetic factors in mental health (Boyle 2002). A third response is to look at the many studies that have found links between social conditions and mental health difficulties (Longden and Read 2016).

A particularly influential piece of research in this area has been the study of the social origins of depression, conducted by Brown and Harris (1978) in Camberwell, an inner-city area of London with (at that time) high levels of deprivation. A community survey was carried out on women in the community who had no contact with mental health services. Participants in the study took part in detailed interviews that made it possible to identify and diagnose the severity of any mental health problems they were experiencing, and also collect information about adverse life events that they had experienced. What the authors found was a significant proportion of women with high levels of untreated depression. Compared with non-depressed women living in the same area, these individuals were more likely to be unemployed single mothers living in high-rise flats, whose

own mother had died before they were 11 years of age. A replication of this study, in Calgary, Alberta, found a slightly different constellation of social factors in depressed women, suggesting that the impact of life events may be community-specific (Costello 1982). These two studies, and many subsequent investigations (for instance, into the ways that unemployment causes mental health difficulties; Olesen et al. 2013), support the hypothesis that psychological, emotional, and relationship problems such as anxiety, depression, and schizophrenia are a response to various types of social disadvantage.

## Conceptual frameworks for making sense of social disadvantage

At the present time, there isn't a single comprehensive theory that makes it possible to understand the ways in which personal well-being can be undermined by factors such as negative life events, poverty, and racism. Instead, there is an interlocking set of ideas that can be characterised as *adversity theory*, which can be defined as the position that all, or most, psychological problems arise from adverse life events. Table 24.1 lists some of the main life events, beyond the control of individual victims, that have been found to trigger psychological and mental health issues. In addition to these specific triggers, the economic structure of contemporary capitalist economies generates massive emotional pain and suffering through such processes as militarisation and warfare, exploitative workplaces, a food industry that actively promotes unhealthy eating, the destruction of the natural environment, dissemination of addictive prescription and street drugs, and the commercialisation and degradation of healthy sexuality through pornography, prostitution, and trafficking. These are all areas of modern life where profits are made, often by international business, at the expense of individual and social well-being.

A distinctive attribute of adversity theory, compared with other explanations of psychological distress, is that it starts from the question 'what has happened to you?' rather than the question 'what is wrong with you?' Asking about 'what has happened to you?' positions the person as resourceful and purposeful in their efforts to recover from bad things that have happened to them, and also as

**Table 24.1** Categories of social adversity

Accident at work	Political persecution
Air or water pollution	Poverty
Domestic violence	Racism
Gender discrimination	Refugee status
Homelessness/inadequate housing	Sexual abuse and violence
Humiliation and bullying	Social isolation and loneliness
Injustice	Stigmatisation or exclusion due to disability, ethnicity, or sexual orientation
Institutional abuse (e.g. children in care)	Trapped in a job or relationship
Loss of a parent in childhood	Unemployment
Parent with mental health issues or alcoholism	Victim of crime
Parental conflict or divorce	Victim of road traffic accident

capable of learning and growing as a result of enduring such episodes. Five main strands of adversity theory are outlined in the following sections: social capital, inequality, weathering, distancing, and place.

## Social capital

The notion of social capital has received a lot of attention in the fields of social and health policy, education, and political sciences over the last 30 years. It is the most broad-based perspective to be developed in relation to human adversity. Although different ways of understanding social capital have been formulated by figures such as Pierre Bourdieu, James Coleman, and Robert Putnam, they all start with the key idea that individuals receive benefits from being members of social networks (Halpern 2005). For example, a person who lives in a close-knit community is buffered against stressful events and losses by having other people to talk to, by being able to seek advice and contacts around specialist sources of help, and by being offered tangible assistance from others. By contrast, an individual who lives in a fragmented community, or one that is characterised by high levels of crime and mobility, is much more likely to struggle when faced with adversity. The effects of low levels of social capital can be observed not in terms of mental health and well-being, but also in such areas as educational attainment, employment status, and physical health.

There are many ways in which contemporary society has contributed to an erosion of social capital. For example, people move to different localities to find work, work longer hours, and engage in individualistic leisure pursuits such as playing computer games and watching TV. One aspect of social capital fragmentation that has been widely studied is the experience of *loneliness*, which has been shown to have a significant impact on a range of mental and physical health problems (Holt-Lunstad et al. 2017). In interviews with people with severe psychological problems, Sagan (2017) found that many of them were able to describe a pattern of loneliness and ‘inner emptiness’ dating back to early childhood, accompanied by an awareness that the strategies they had developed to cope with loneliness had generally made things worse.

### Box 24.1: How support group membership facilitates social capital formation among female survivors of domestic violence

A qualitative study by Larance and Porter (2004) used interviews and participant observation to collect information about the effectiveness of a 12-week psycho-educational therapeutic support group for women who had been subjected to domestic violence. At the start of therapy, the women in this group all experienced ‘severed relationships’ as a result of the ways in which their male partners had forced them to break their contacts with friends and family members in order to focus on the partners’ needs. At a later stage, this sense of social isolation was exacerbated by the requirement to conceal signs of injury from physical violence. Although the women in the group benefitted from learning about new ways of making sense of domestic violence, and sharing their stories in the group, the most significant therapeutic benefit of the group appeared to consist of a gradual process of rebuilding social networks and social capital. Larance and Porter (2004) described how the women met informally before the group, during break time, and after the group, shared telephone numbers for contact outside group, and planned social events together. Over time, the women became more and more involved with one another beyond the confines of the therapy agency, through activities such as looking after each other’s children, helping each other move house, and accompanying each other to court proceedings.

## Inequality

Analysis of levels of physical and social well-being across different societies has found a strong relationship between well-being and income inequality (James 2007; Marmot 2004; Pickett and Wilkinson 2010; Pickett et al. 2006; Wilkinson and Pickett 2010). Societies with higher levels of equality record higher levels of well-being. This correlation holds regardless of absolute income level – poorer societies that are more equal do better than wealthier societies that exhibit high rates of inequality. There appear to be a range of factors that contribute to this pattern. In more equal societies, for example, individuals are more likely to cooperate and support each other, rather than view one another as competitors. High levels of inequality are associated with the widening of the gap between social classes, with the richest 10 per cent occupying different geographical areas and more likely to define poorer people as lazy and a burden. This kind of social splitting results in tax avoidance on the part of the rich, such as through the use of offshore tax havens, which reduces the amount of money available for education and social services. Inequality also leads to higher rates of spending on police and prison services (to keep rich people safe), which is a burden on public spending. The existence of a rich elite is inevitably built on the indebtedness of the majority, through rents and interest on loans. Psychologically, there are higher levels of subjective relative deprivation in unequal societies (Mishra and Carleton 2015), which takes the form of people being dissatisfied with their own apparent failure, and being driven to work long hours to try to earn more.

Research by Gilbert et al. (2009) illustrates one of the ways in which inequality is linked to emotional problems. In a study of people who were depressed, Gilbert et al. found that when people are aware of being subordinate – or losers – in a clearly defined hierarchy, they experience a fear of rejection that increases vulnerability to depression, anxiety, and stress. This pattern holds for anyone at any level of a status hierarchy. Further examples of ways in which inequality and the fear of being a social ‘loser’ can impact on emotional well-being can be found in James (2010).

To some extent, inequality as a driver of mental health problems is conceptually similar to social capital theory discussed previously: both perspectives point to the link between an absence of social solidarity and psychological distress. However, while social capital can be rebuilt by local community action, differences in income inequality can only be addressed through structural changes at the level of the state.

## Weathering

The concept of *weathering* refers to a process of being ground-down by unremitting exposure to negative experiences (Geronimus 2001). A similar concept, originally developed in the field of the psychology of racism, is *microaggression*: the process of being subjected to constant and continuing subtle slights, invalidations, and indignities on account of being ‘different’ through reason of race and ethnicity, gender, disability, or sexual orientation (Sue 2010). A further perspective in this area is the *conservation of resources* model of stress (Hobfoll 1989, 2001). In this model, people who are satisfied with their lives are able to draw on an array of positive resources (such as support from others, access to money, ability to use knowledge and skills) when faced with difficulties in their life. Those who enjoy sufficient resources find it relatively easy to build up additional resources. By contrast, individuals whose resources are depleted may enter a negative spiral where each setback leaves them less able to cope with whatever might happen next. The concept of weathering was initially used to refer to the way in which African American women in the USA carry enormous family responsibilities while at the same time battling against constant threats to their safety, security, and health, and as a result become ill. An interview study by Warren-Findlow (2006) vividly describes this kind of experience.

It seems appropriate to apply the notion of weathering more widely, as a means of making sense of people who come to therapy without one specific trauma or issue to work on, but instead seem generally emotionally and physically depleted and describe a life characterised by a struggle to do their best in the face of a wall of adversity, in the form of lack of money, poor housing conditions, exposure to criminality, a lack of work, or work that is exhausting, low-paid, and degrading.

Weathering is a way of thinking about stress that acknowledges a process of gradual erosion of hope and dignity, beyond the control of the individual.

## Distancing

The concept of distancing was used by Lott (2002) to describe the way in which members of social groups considered to be ‘other’ or ‘lesser’ are made invisible by those who enjoy more comfortable or protected lives. Subtle everyday examples of distancing occur when a person walks around someone begging in the street, or switches channel when a TV news item about child poverty is being shown. Distancing can become institutionalised in the form of social exclusion – those who do not wear the right clothes or talk in the right way are excluded from certain clubs and jobs. Children whose parents cannot afford to pay for school trips are excluded from participating in the cultural life of the school. Some forms of distancing are far from subtle: TV series about benefit scroungers and government policies that mean that people either use foodbanks or in some cases starve to death.

Being on the receiving end of exclusion or distancing is a type of microaggression that is stressful and weathering. In relation to counselling and psychotherapy, there are many people who feel as though they don’t belong in the therapy room: ‘it’s not for the likes of me’. Crucially, also, therapists are forced to confront their own distancing strategies when faced with a client with whom, in other circumstances, they would actively avoid making contact.

## Place

To view the social world as comprising institutions and relationships runs the risk of missing a crucial dimension that is reflected in terms such as space, place, and emotional geography. Good and bad experiences are associated with places (Bierski 2016; Duff 2012; Smith et al. 2015; Walker et al. 2017). In relation to the aims of counselling and psychotherapy, clients may talk about how they avoid certain places and regard other places as sources of healing. Therapy can be part of a process of building a world in which there are enough good places. For example, a person who is depressed and isolated may, with a lot of support from a counsellor, arrive at a point at which they get a job that gives them a place where they belong, have meaningful contact with other people, and do useful work.

These ways of thinking about social causes of psychological distress – social capital, inequality, weathering, distancing, place – seek to give a tangible form to the underlying ‘isms’ that are so corrosive to authentic relationship: racism, sexism, colonialism, classism, and so on. They are intended to offer a tentative framework for constructing an adversity model that provides an alternative to the medical and psychological perspectives that dominate contemporary counselling and psychotherapy theory and practice.

### Box 24.2: The enduring legacy of Erich Fromm

Erich Fromm (1900–1980) was a German sociologist, psychoanalyst, and philosopher who emigrated to the USA in 1934 and spent most of his life working in New York and Mexico. Although he is perhaps best known for his existentially oriented writings on themes such as love, death, authenticity, and spirituality, he is one of the few therapists to have developed a theoretical understanding of the ways in which the pressures and expectations resulting from living within a capitalist society have an influence on the personality and emotional life of the person. As with many European intellectuals who had lived through the Nazi era, Fromm believed in the reality of an *authoritarian* personality type, exhibited in individuals who conformed to the commands of those who they regarded as being of higher status. Fromm also referred to a *marketing* character style, organised around the demands of doing well in the marketplace. Finally, Fromm described a *necrophilous* character style, oriented towards the use of violence and force to deal



with problems, and a lack of belief in the possibility of love or connectedness. Fromm carried out extensive field research in Mexico, testing these theories – work that was never adequately published in English (Thomson 2009). While the language and terminology used by Fromm is dated, his ideas are increasingly being regarded as essential starting-points for making sense of issues in contemporary society (Friedman 2013; Rasmussen and Salhani 2008).

## Social interventions

A social perspective not only makes it possible to understand the reasons why people develop problems in living and find it hard to deal with those problems, it also generates many strategies for helping people to learn and change. The following sections describe some social interventions that counsellors and psychotherapists can integrate into therapy with their clients.

### Generic social repair processes

As a whole, counselling and psychotherapy represent individualised forms of help and support that do not directly address social dimensions of personal suffering. However, it is possible to identify some generic social repair processes that may occur within routine therapy practice. People who seek therapy have often been silenced in relation to the adversities they have experienced. This may be because they lack concerned others who are willing to listen to their story, because they have been threatened with violence if they speak up (such as victims of sexual abuse), or because their experiences are just emotionally very hard to talk about. Good therapy allows people to break their silence and tell their story, in ways that may then enable them to speak out in other settings or even to seek redress (McLeod 1999). Good therapy may also create a sense of personal purposefulness and agency that allows people to re-build their own lives and contribute to building better communities. The experience of being in therapy may allow people to learn at first hand about the importance of listening and feeling, and the value of relationships. Therapists become witnesses to hidden social injustice and tragedy, putting them in a position to influence political decision-making and debate. These are some of the ways in which ordinary therapy may have positive social outcomes.

### Constructing social solidarity: narrative therapy

Some counsellors and psychotherapists seek to go beyond individual empowerment, and use the experience of therapy to help clients to construct social networks and institutions that have the potential to create a more just society. The therapy approach that most explicitly espouses such objectives is narrative therapy (discussed in more detail in Chapter 14). While its title and much of its theoretical rationale emphasise the importance of narrative, storytelling, and discourse as sources of identity, in practice narrative therapy can be regarded as a form of social action. The process of narrative therapy typically invites the client to consider the question of who in their life knows and cares about their struggle with a particular problem, and thus could function as a source of knowledge and support. The later stages of therapy tend to focus on making contact with other people, and initiating or joining some type of communal grouping that supports a satisfying and meaningful way of relating to others. The literature on narrative therapy generally incorporates the notion that individual or family therapy is a form of *community work*, and that therapeutic processes can be integrated into practices with real-life groups in such settings as schools, prisons, and refugee camps (Denborough 2014; Denborough et al. 2008).

### Using therapy to undo the effect of social degradation and humiliation

An example of how psychotherapy can be used to address a specific category of social adversity can be found in the work of Raymond Bergner (1987, 1993, 1999, 2007, 2015; Bergner and Holmes 2000;

Bergner and Staggs 1987; Torres and Bergner 2012). Over more than three decades, he has developed a 'sociodynamic' approach to working with clients who have experienced severe public humiliation. An example, described in Torres and Bergner (2012), is the case of W, an African American man who had had a successful career as an officer in the US military. On one occasion, a famous politician visited the base, and made a point of looking all the other officers in the eye and thanking them for their work. He did not look at all at W, and in fact turned his back on W throughout the visit. After this event, W felt ashamed and humiliated, he felt worthless, his mood and work performance deteriorated, and eventually he was referred for therapy. It took some time for his therapist to uncover the cause of W's emotional and personal crisis. The main elements of therapy were to establish the therapist as a credible representative of societal values who had the power to 're-accredit' W. Other aspects of therapy involved reframing the event, in a way that challenged the right of the visiting politician to have done this to W. In other similar cases, the precipitating event might also need to be worked on as an instance of trauma.

Further development of this approach has involved the concept of the 'unliveable world' into which the humiliated person is thrown, and the links between this experience and suicide (Bunford and Bergner 2012). A similar perspective on humiliation, but with a starting point in psychodynamic theory and practice, can be found in Leask (2013), who emphasises the distinction between 'shame' as a state of mind and 'humiliation' as a social act, and suggests that it is therapeutically valuable to focus on the specific of the humiliation event.



### Case study 24.1: The case of Tracy

Tracy was in foster care having endured a lifetime of neglect and abuse from a mother who had eventually abandoned her at a homeless shelter. She had undergone profound traumatic humiliation arising from the degrading rejection of not being lovable enough for her mother to care about her. At the point of entering therapy, she was unable to name one person who could offer her a sense of safety and connection. She had become habitually angry and aggressive as a way of coping that prevented further disappointment. Hartling and Lindner (2016) describe the healing effect of being offered a supportive therapeutic relationship with a counsellor who believed in Tracy's capacity for growth. Over time, this connection allowed Tracy to discover a passion for art, which was then reinforced by the attentiveness of a teacher who recognised her potential and offered encouragement. Together, these activities provided her with a 'foothold' into a life with a future and opportunities to begin to build positive social capital.

## Befriending

The practice of *befriending* refers to a socially oriented form of support in which a person experiencing some kind of difficulty meets with a helper to engage in some kind of social interaction and participation that is relevant to them. Although befriending can take many forms (Thompson et al. 2016), a typical example is a service operated by a voluntary agency in England, in which people with severe long-term mental health problems were visited on average once each week (Bradshaw and Haddock 1998). The activities undertaken by the befriender and befriender varied according to the needs and preferences of the person being supported, but might include talking, walking, shopping, cooking, and going out for a coffee. In this project, interviews with clients indicated high levels of satisfaction with the service, a wish that befrienders would visit more often, and reported gains in social confidence and reduced anxiety. A review of research into the effect of befriending on symptoms of depression found benefits that were moderate (i.e. less than the effect of psychotherapy) but

nevertheless significant and worthwhile (Mead et al. 2010). The process of befriending appears to be rather similar to the process of counselling and psychotherapy, with a key element being the establishment of the relationship of trust within which the person could share their feelings (Mitchell and Pistrang 2011). Compared with formal therapy, the advantages of befriending are that it is more flexible, less costly, and more directly focused on social interaction and building social networks. Another advantage is that befriending tends to be experienced by the befriender as a highly meaningful learning experience (Greenwood et al. 2016; Smith et al. 2017).

## Social involvement initiatives

Beyond befriending, there exists a huge range of other strategies for using social participation and involvement as a means of addressing mental health issues. There is substantial evidence for the effectiveness of these approaches (Nagy and Moore 2017; Webber and Fendt-Newlin 2017). An example of the nature and scope of such interventions can be found in the Poder es Salud (Power for Health) project (Michael et al. 2008), which operated over an 8-month period in Multnomah County, Oregon to reduce levels of health problems in Latino and African American communities. The many activities initiated included a business incubator, a public safety committee, a girls' leadership group, a diabetes support and education group, a homework club, an environmental health project that employed photovoice, a women's soccer team, an Aztec dance class, a peace campaign, popular education classes about gang violence, and chronic pain support groups. In respect of mental health issues, follow-up data on those who had taken part showed substantial improvements in symptoms of depression, and an increase in social support (someone to talk to).

Other community activities that have been used with the aim of improving psychological and emotional well-being include men's sheds, urban gardens, many different types of expressive arts and outdoor exercise projects, and supported employment initiatives. Typically, counsellors, psychotherapists, and other health practitioners are involved at the level of providing training, consultancy, and support for members of the community responsible for organising and delivering such schemes. These activities may be aimed at individuals with specific problems, or may be open to anyone in the community. Quite often, they are described in terms that do not include diagnostic or problem labels. Taking part in social involvement is often fun and offers a source of positive emotions and memories. The aim is usually to set off something that will be self-sustaining and can become part of the social capital available to members of a community.

## Social matrix dreaming

Social matrix dreaming was developed by Gordon Lawrence (1934–2013), a social scientist based at the Tavistock Institute in London, a leading international centre for psychoanalytic research, practice, and training. The idea for social dreaming came originally from a book by Charlotte Beradt, *The Third Reich of Dreams* (1986), a collection of dreams by people in Germany in the period immediately before the Second World War. What was very clear from these dreams was that similar themes emerged across different dreamers, even though they had no contact with each other. In addition, taken as a whole, a body of dreams by members of the same community vividly expressed the underlying or unconscious tensions and conflicts being faced by the group.

Building on the ideas of Freud, Jung, and Bion, as well as studies of dream-sharing in traditional cultures, Lawrence (2003a, 2003b, 2007, 2010) went on to devise a structure where a group or matrix of people would share their dreams, then free associate to their dreams over a period of time. This approach turned out to be highly valuable in social research and organisational development contexts, as a means of allowing a group of people to think collectively in a deeper and more creative way about common tasks with which they were engaged. Examples of how social matrix dreaming has been used in peer support networks can be found in Price (2017), van Beekun and Laverty (2007), and Slade (2005). Social matrix dreaming has obvious potential as a community-based adjunct to individual therapy as well as playing a part in social intervention programmes.

## Prevention

The concept of prevention represents a key element in any social perspective on counselling and psychotherapy. Prevention can take place at various levels. For example, emotional intelligence training in schools has the potential to prevent individuals from ever developing psychological and relationship difficulties in later life. Other prevention initiatives aim to catch problems early, before they have become too serious. Some organisations may invite employees to complete an anonymous self-scoring symptom or stress measure on a regular basis, along with a reminder of available services from occupational health and counselling. In some instances, prevention can involve the identification of people who are at risk. An example here would be first-year university students who miss two consecutive classes without submitting sickness notes from a doctor. Relapse prevention may involve keeping in touch with clients who have completed therapy, or providing them with a helpline or survival plan in case they detect signs of their problem returning. There have also been large-scale programmes developed around concepts such as mental health literacy, mental health first aid, and how to respond to someone who is suicidal. Further reading on different prevention-oriented intervention strategies can be found in Bovopoulos et al. (2016), Conley et al. (2017), and Hadlaczky et al. (2014). An important dimension of prevention has been the training in counselling skills for frontline professionals in occupations such as education, social work, nursing, and criminal justice (McLeod and McLeod 2015).

### Box 24.3: A lack of social support makes it difficult for people to benefit from therapy

Most counselling and psychotherapy focuses on psychological difficulties that make it hard for the client to have a satisfying life – processes such as self-undermining ways of thinking, unresolved trauma, or regulation of emotions. The development over the last 20 years of brief outcome measures, which clients complete at every session, has made it possible to track client progress over the course of therapy. An important discovery arising from this work has been that when these scores are plotted on a graph, often the pattern does not represent a gradual curve. Instead, some clients exhibit sudden gains (where they improve substantially between one session and the next), a pattern that tends to lead to eventual good outcomes at the end of therapy. Another pattern is sudden deterioration, where the client becomes substantially worse between sessions. This kind of event tends to be associated with unsuccessful therapy or dropping out of treatment.

Probst et al. (2015) and White et al. (2015) have looked closely at what is happening when a client reports sudden deterioration. Their expectation was that this phenomenon would reflect either poor motivation for therapy or a rupture in the alliance with the therapist. They were surprised to find that, although both of these factors were apparent in some cases, the single most important precipitant of sudden deterioration was a lack of social support, expressed in low ratings to questionnaire items such as ‘I could count on my friendships when things went wrong’, ‘There was a special person who was around when I was in need’, and ‘I could get material support if needed (like: money, food, transportation, childcare, tools, repairs, health care, legal advice, etc.)’. These are statements that also appear in many social capital questionnaires. The implication of these findings is that, in a significant proportion of cases, lack of attention to the extent and quality of social support available to the person has the effect of undermining the effectiveness of therapy. In a separate research programme, Hallgren et al. (2017) found that access to supportive social relationships made a substantial difference to whether or not someone receiving therapy for depression had a good outcome.

## The significance of social class, social status, and poverty

Many of the themes discussed in this chapter converge around the issue of social class. Interest in the distinctive psychological problems associated with poverty and social status can be traced back to Alfred Adler and Wilhelm Reich, and research into social class and psychotherapy has been conducted for decades (Bromley 1983; Garfield 1986; Lener 1972). Nevertheless, contemporary theories of therapy are almost entirely silent around the potential significance of social class.

A review of research into therapy for depressed low-income women found that, although the evidence suggested that therapy could be beneficial, potential clients had great difficulty in accessing services (Levy and O'Hara 2010). In a study of the attendance patterns of patients referred for psychotherapy in NHS clinics in a region of the north of England, Self et al. (2005) reported that clients who lived in neighbourhoods of high social deprivation were more likely to fail to attend their first appointment, and to quit therapy before their fifth session, compared with clients from more prosperous localities. On the other hand, Self et al. (2005) also found that there was no difference in attendance or benefit reported by working- and middle-class clients who stayed in therapy beyond five sessions.

Why is it hard for people from deprived backgrounds to engage with therapy? At one level, there may be practical difficulties such as being unable to take time off work, afford the cost of travel to a therapy clinic, or cover childcare needs. Beyond these practical issues is the fact that, on the whole, counsellors and psychotherapists are middle class, and may not sufficiently understand what it is like to struggle to make ends meet or to cope with unremitting and destructive weathering and microaggression.

Some research has shown that counsellors and psychotherapists hold negative images of working-class clients. Laura Smith and her colleagues (2011) carried out a study in which a large number of students on a counselling training programme were asked to read a package of information about a new client, and then respond to some questions regarding their views on how therapy might proceed with that client. The information package was the same for all participants, except that, for half of the sample the client was described as middle class and for the other half the client was described as working class. The students who believed that the client was working class predicted that therapeutic progress would be slower and more difficult than students who had been informed that the client was middle class. Similar findings were reported by Dougall and Schwartz (2011) in a sample of more experienced therapists. However, Thompson et al. (2014), in a more recent study with experienced therapists, found no difference in the ways that participants responded to vignettes describing a lower- or upper-class client.

Some researchers have interviewed therapists about their real experiences of working with clients from different social class backgrounds. Ryan (2006) found that middle-class therapists, paired with working-class clients, were aware of an underlying sense of guilt, arising from privilege, and an inhibition around exploring certain topics in case they triggered 'class-based anger' on the part of their clients. Ballinger and Wright (2007) and Ryan (2006) described therapists as being aware of difficulties associated with social class differences, while at the same time realising that their training and supervision had not prepared them sufficiently to address such issues. Similar themes emerged in interviews with mental health practitioners conducted by Thompson et al. (2015), along with a perception that working with economically disadvantaged clients was highly meaningful and involving but also extremely challenging in terms of the complexity of their problems and needs.

Other studies have explored the experiences of clients in relation to working with a therapist from a different social class background. Balmforth (2006, 2009) interviewed working-class clients about their experiences of seeing therapists who they perceived as being upper or middle class. Many of these clients reported that they had felt uncomfortable, inferior and misunderstood, unable to form a productive relationship with their therapist, and unable to talk about these difficulties. Cormack (2009) interviewed homeless young people about their experiences of counselling and found that most of them were extremely negative about the help they had been offered. These young



people described themselves as unwilling to trust their counsellor and experiencing themselves as 'trapped' in the counselling room. A similar study by Thompson et al. (2012) found that low-income clients believed that their therapist just did not 'get it' in respect of the realities of economic and social disadvantage. However, this study also described some positive examples of middle-class therapists building productive therapeutic relationships with their low-income clients. Pugach and Goodman (2015) interviewed ten low-income women in the USA about their experience of therapy, with a particular focus on what they had found helpful or unhelpful. For these women, what was most helpful was working with a therapist who was aware of the nature of poverty and poverty-related stressors, had some sort of direct exposure to poverty, provided practical support, and focused on their strengths.

Few studies have looked at the expression and exploration of class-related issues in therapy sessions. Based on transcripts of therapy sessions with clients with depression, Falconnier and Elkin (2008) analysed the extent to which clients raised economic concerns and the ways that their therapists responded. The clients in this study were a representative sample of the American population, seen in a university clinic setting. Nevertheless, 86 per cent of them mentioned economic, financial, or employment worries in early sessions. Therapists were generally responsive to these topics, even though the design of the study required them to adhere to a treatment protocol that emphasised cognitive and interpersonal processes rather than social issues. The therapists seemed to have most difficulty in responding to financial concerns, typically changing the subject when this issue arose. Cases in which therapists were more responsive to economic concerns recorded better outcomes than cases where therapists were less responsive to such themes. In a further article based on the same data set, Falconnier (2009) reported that there was a slight tendency for working-class clients to benefit less from therapy than middle- or upper-class clients.

In a study of a community-based voluntary sector bereavement counselling service in Scotland, Newsom et al. (2017) looked at differences between clients who were defined as living in poverty (36 per cent) and those who were financially more secure. Clients in poverty had much higher complicated grief scores, were more likely to be taking antidepressant or anti-anxiety medication, and were less likely to take up the offer of counselling after making initial contact. However, the effectiveness of counselling, reflected in a decrease in grief scores, was similar across the poor and more financially secure groups of clients.

An important dimension of social class is access to secure, well-paid employment. There is considerable evidence that the loss of employment can have a significant negative impact on mental health and well-being and that, for people without a job, securing employment can reduce the symptoms of anxiety and depression (Allen 1999; Fryer and Fagan 2003; Murphy and Athanasou 1999). A review of research into the psychological effects of unemployment by Murphy and Athanasou (1999) suggests that, for someone who is unemployed, the effect of gaining a job is broadly equivalent to the effect of receiving therapy. There is some evidence that therapy may be less effective with people who are unemployed than those who are in work but in low-wage jobs (McLeod et al. 2000; Saxon et al. 2008). This may be because being in work gives a person more opportunities to practise new behaviours (e.g. with work colleagues) that are discussed in therapy sessions.

The studies outlined above provide useful clues to the kinds of factors that need to be considered when designing therapy services that are sensitive to issues of social class. The research evidence in this area is fragmented and limited, and at the present time raises questions rather than provides answers. It is evident that there does not exist a coherent body of theory and research on the psychotherapeutic issues associated with either the negative (e.g. lack of money, poor housing conditions or homelessness, job insecurity or unsatisfying work, powerlessness) or the positive aspects of working-class life (e.g. solidarity, direct language, family cohesiveness).

Research into therapy with people who are economically disadvantaged has developed guidelines around how to work with such clients. The papers by Appio et al. (2013), Foss-Kelly et al. (2017), and Goodman et al. (2010) are especially highly recommended. Common themes across these guidelines include: the establishment of a genuine relationship; a therapist who has examined their own



experiences and prejudices around social class and poverty (Ali and Lees 2013; Ali and Sichel 2014); a therapist who is actively willing and interested in exploring issues around practical needs and money (Hawkins and Kim 2012); and an approach that works to build strengths and resources. In addition, attention needs to be paid to access to services, in terms of location, cultural sensitivity, outreach, and childcare (Santiago et al. 2013).

## The significance of affluence and privilege

Many people who seek therapy are economically comfortable or even wealthy, and do not appear to have experienced any kind of social adversity whatsoever. However, the psychological and emotional problems reported by such individuals can still be understood in social terms. They may experience themselves as locked into a stressful cycle of needing to make more and more money in order to support an ever-expanding consumer lifestyle. This may be associated with a sense of entitlement that undermines authentic relationships. In Britain and some other countries, close attachments and an experience of close family life may be affected by attendance at boarding school (Duffell and Basset 2016). Further discussion of the emotional costs of affluence can be found in James (2007) and Wachtel (2016).

## Evaluating the social outcomes of therapy

The methods that are used to evaluate the effectiveness of therapy are important. Increasingly, governments and other health providers use evidence from outcome studies to guide them in deciding which kinds of therapy should be made available. In addition, many therapists ask clients to complete brief outcome measures each week, and use this information as a basis for talking about whether therapy is going in the right direction. These instruments are almost entirely based on self-rating of psychological symptoms of anxiety, depression, and stress. Kazdin (2006) has described them as ‘arbitrary metrics’ that do not capture what is happening in the social life of the client. If a social perspective is to become part of therapy practice, it is essential to develop means to collect information about the ways that the social lives of clients are being affected, and also the broader impact on families, communities, and workplaces. There are many possible ways to do this. Interviewing clients, with a focus on social aspects, is one strategy. In terms of using questionnaires that make it easier to study large samples of clients, it is surprising that no one seems to have looked at Erik Erikson’s concept of *generativity* (making a contribution to society) as a therapy outcome measure. Techniques for measuring generativity have been available for a long time (McAdams and de St. Aubin 1992). Another possibility is to use measures of relevant social capital factors (Verduin et al. 2014).

## Conclusions

This chapter has offered a short introduction to the broad and complex topic of how social conditions create emotional and relationship difficulties, yet at the same time provide resources that can be used to resolve these problems. On the whole, counselling and psychotherapy have tended to promote an individualised concept of the person, and have paid little attention to social factors. In his authoritative account of the history of psychotherapy, Cushman (1995) identified many points at which therapy theory and practice have had the choice to follow a more socially informed path, but every time have chosen the alternative. The current situation represents another of these choice-points. Counselling and psychotherapy are mature, well-established professions that can draw on more than 50 years of research and practice development. The evidence presented in this chapter suggests that individualist therapy has gone as far as it can go – any further improvements in the

accessibility of therapy and its value to individuals can only arise from a serious effort to engage with the social. The necessity of such engagement at the present time is further emphasised by the fact that society is experiencing a further widening of income inequality (Piketty 2014). Embracing the social is likely to be an uncomfortable journey for therapists. It calls for a re-think of theory, an acknowledgement of privilege, and the building of new professional alliances.



### Topics for reflection and discussion

- 1 Identify one psychological, emotional, or relationship issue that you have struggled with in your life. What does this issue look like, if understood wholly in social terms, using concepts such as adversity, social capital, inequality, weathering, place, and distancing? Does a social perspective suggest new ways that might have been used to address this issue?
- 2 If you are a therapist, apply the previous instructions to develop a social perspective on one of your clients.
- 3 How do you view yourself, in terms of social class? How do you relate to people who you perceive as coming from other social classes? What are the implications of your response to these questions for your experience of being a client or a therapist?
- 4 If you were to see a therapist, how valuable would it be to use it as an opportunity to explore your thoughts, feelings, and concerns about your financial situation? What might you learn or gain from such a conversation?
- 5 If you were to see a therapist, how valuable would it be to use it as an opportunity to explore your thoughts, feelings, and concerns about your experience of humiliation? What might you learn or gain from such a conversation?
- 6 In the community where you live, or organisation where you work, what could be done to prevent people from developing mental health problems?

### Suggested further reading

One of the most stimulating writers and researchers in the area of social aspects of therapy is Lisa Goodman (see, for example, Goodman et al. 2004, 2009, 2010; Pugach and Goodman 2015). Derek Milne is one of the leading figures in the CBT community in the UK. His book, *Social Therapy: A Guide to Social Support Interventions for Mental Health Practitioners* (1999), is considered a crucial contribution to socially oriented practice.

# Chapter 25

## Gender and sexuality

<b>Introduction</b>	<b>376</b>
<b>The therapeutic significance of gender</b>	<b>377</b>
<b>Gender-informed approaches to therapy</b>	<b>379</b>
Feminist therapy	379
<i>The feminist critique of psychotherapy theory and practice</i>	380
<i>The emergence of feminist counselling and psychotherapy</i>	381
<i>Relational-cultural therapy</i>	382
<i>The development of a feminist ethics for therapy practice</i>	384
<i>The contribution of feminism to counselling and psychotherapy</i>	385
Therapy for heterosexual men	386
Gender and sexual diversity	387
<b>Therapy for sexual concerns</b>	<b>390</b>
<b>Abusive sexuality</b>	<b>392</b>
<b>Conclusions</b>	<b>393</b>
<b>Topics for reflection and discussion</b>	<b>393</b>
<b>Suggestions for further reading</b>	<b>394</b>

### Introduction

Being male, female, intersex, or any other way of identifying represents a core dimension of personal identity for most individuals. The expression of sexuality in relationships, and in areas of life such as art, dance, music, and fashion, is a crucial source of intimacy and pleasure but it can also be a source of conflict and abuse. Being and becoming a boy or girl is a central theme in child and adolescent development. There are major cultural, subcultural, and intergenerational differences around gender and sexual values and behaviour. In terms of both academic and everyday discourse, gender is a topic that can be addressed from biological, social constructionist, and many other points of view. There is no doubt, therefore, that sex and gender are hugely important.

It is surprising, therefore, that gender does not feature more prominently in mainstream therapy theory and practice. The idea of sexual or libidinal drives, and a radical (at that time) position of

acceptance of sexuality, were at the heart of classic psychoanalytic theory. Since that time, however, the counselling and psychotherapy community appears to have been in steady retreat from this aspect of human existence. Despite enclaves of interest, such as sex therapy, feminist therapy, and therapy for or with people with diverse genders and sexualities, it is safe to assume that the majority of clients go through therapy without talking about their gender identity or sexuality at all.

This chapter explores some of the ways in which gender and sexuality are relevant for clients and therapists and thus deserve attention. Gender is taken to refer to personal, cultural, and social meanings and choices around male/female identity, while sex is taken to refer to biological aspects (Richards and Barker 2013). Because feminism represents the most coherent and comprehensive approach to understanding the role of gender in therapy that is currently available, a major part of the chapter is devoted to an introduction to feminist perspectives on therapy.

## The therapeutic significance of gender

Gender is such a taken-for-granted dimension of social interaction that most of the time we do not notice it. Gender-informed therapy therefore needs to start with a capacity to be aware of this aspect of the therapy process. Because the gender identity of each individual person, including clients and therapists, is shaped by multiple contexts, life experiences, and choices, it is not helpful to make broad-brush general statements such as ‘women are more effective therapists than men’ or ‘men are more resistant to entering therapy than women’: it is not hard to find men who are excellent therapists, or women who are extremely reluctant to make use of therapy. Rather than providing certainties, it is more useful to regard theory and research around gender processes in therapy as ways of sensitising therapists and clients to *possible* areas in which it might be valuable to make sense of what is happening from a gender perspective. Some of these areas are explored next.

*Client experiences.* For most people who enter therapy, the choice of a male or female therapist, or the experience of being allocated to a male or female therapist, will carry a great deal of meaning. Therapists seldom invite clients to talk about this aspect of the process of entering therapy. However, in a piece of qualitative research by Gehart and Lyle (2001), clients who had received therapy from both a male and female therapist were interviewed about this experience. These clients had a lot to say about the different ways they connected with male or female therapists, and how they found themselves talking about different topics, depending on the therapist’s gender. Their stories did not depict male or female therapists as necessarily better – they were just different.

*Internalisation of the therapist.* One of the ways that the meaning of what has been explored in a therapy session is transferred to everyday life is through the client remembering things that the therapist has said. In one study, Farber and Geller (1994) found that female clients working with male therapists were more likely than male clients working with male therapists to have strong memories of their therapist between sessions.

*How easy or hard it is to disclose painful experiences.* Self-disclosure is a key process in therapy – the role of client involves an expectation of telling one’s therapist about experiences that may be shameful, embarrassing, or emotionally painful. In a study of differences in how male and female clients felt about disclosure to their therapist, Pattee and Farber (2008) found that female clients working with female therapists reported greater distress in disclosing than either male clients working with female therapists or female clients working with male therapists. They also found that clients who could be classified as ‘androgynous’ (i.e. did not strongly identify themselves as possessing either male or female traits) found it easier to disclose than did clients with more conventional gender identities. Pattee and Farber (2008) interpreted these findings in terms of two factors. First, they

suggested that female therapists may elicit feelings of inadequacy, competition, or being judged in their female clients. Second, female clients (or at least some of them) may unconsciously experience male therapists as benevolent authority figures and 'safe havens'.

*The effectiveness of different types of intervention.* Several studies have shown that responsiveness to various interventions is influenced by whether the client is male or female. For example, in one study women did better than men in CBT for trauma (Békés et al. 2016). This group of researchers attributed their findings to the fact that women appeared to be more able to articulate their experience, even right at the start of therapy, and as a result became more involved (Bisson Desrochers et al. 2016). Another explanation might be that possibly the 'default' coping mode for women is emotional expressiveness and social support, and that CBT provided a set of cognitive strategies that offered them a new set of coping skills. By contrast, the men in this study were offered more of the same coping strategies that had already proved insufficient in dealing with their experience of trauma. It is possible that different gender-based factors may have been significant for different clients. Nevertheless, the overall finding that there were gender differences in outcome suggests that, to enhance the effectiveness of the therapy they deliver, therapists might benefit from adopting a gender-informed perspective.

*Gender competence of therapists.* While there is no consistent evidence of greater effectiveness of either male or female therapists, it does appear that therapists can differ in how successfully they work with either men or women. A study carried out by Owen et al. (2009) found that some therapists did better with male clients, some did better with female clients, and others did equally well or equally badly with male and female clients. This pattern held for both male and female therapists.

*Therapist use of counselling skills.* In a large-scale study involving therapists from several theoretical orientations, Staczan et al. (2017) found that, on the whole, the gender of the therapist did not have an influence on the development of a therapeutic alliance or the eventual outcome of therapy. However, they did observe significant differences in the skills that therapists deployed. The female therapists used more empathic responses than the male therapists. Additionally, within the group of humanistic therapists included in this study, the men used more confrontation than their women colleagues. These differences were not a matter of therapist self-perception – ratings of therapy transcripts were made by independent judges who did not know the gender of the therapist whose performance they were analysing. Also, these skill differences did not translate into good or poor outcomes in a linear fashion. For example, some clients appeared to benefit from empathic responses, while other clients did not.

There has been no intention to assemble a comprehensive review of theory and research around each of these themes: there is a paucity of research in this area, and at the present time it would be hard to construct any kind of plausible systematic review of findings. Instead, the aim has been to invite reflection on some of the ways in which gender may influence therapy, at least in some circumstances and in some cases. A key implication of the studies highlighted above is that it may be helpful for both clients and their therapists to pause occasionally, take stock, and reflect on the degree to which their interactions are following a 'gendered' pattern, or are being shaped by assumptions about what it means to be male or female and how men and women relate to each other. It is important to take account of the fact that all of the studies discussed above were based on clients and therapists from white, Judeo-Christian, European/North American cultural backgrounds. Clearly, there are strong cultural differences in gender norms and relationships, and similar studies carried out with other cultural groups would likely come up with different results.

## Gender-informed approaches to therapy

The material in the previous section focused on gender processes within routine, everyday therapy, with the aim of establishing that gender matters. The following sections explore the inevitable implications of these themes: if gender is an important aspect of therapy, then why not develop ways of doing therapy that are explicitly informed by gender awareness? The initiatives that have followed this path can be divided into three broad groupings: feminist therapy, therapy for heterosexual men, and therapy that is responsive to gender and sexual diversity.

### Feminist therapy

Feminist perspectives represent one of the most significant areas of advance in counselling and psychotherapy theory and practice over the past 20 years. The basic assumption of feminism is that, in the vast majority of cultures, women are systematically oppressed and exploited. Howell (1981) describes this state of affairs as ‘the cultural devaluation of women’; other people would label it as ‘sexism’.

The ways in which a male-dominated social order is created and maintained have been subjected to critical analysis by many feminist scholars. Enns (1992) has divided the ‘complex, overlapping and fluid’ perspectives that operate within feminism into four main feminist traditions: liberal, cultural, radical, and socialist. *Liberal* feminism can be regarded as the ‘mainstream’ feminist tradition, and has its roots in the struggle of the Suffragettes to gain equal rights and access. *Cultural* feminism, by contrast, placed greater emphasis on recognising and celebrating the distinctive experience of being a woman and promoting the ‘feminisation’ of society through legitimating the importance of life-affirming values such as cooperation, harmony, acceptance of intuition, and altruism. *Radical* feminism centres on a systematic challenge to the structures and beliefs associated with male power or patriarchy, and the division of social life into separate male and female domains. Finally, *socialist* feminism is derived from a core belief that, although oppression may be influenced by gender, it is determined at a more fundamental level by social class and race. For socialist feminists, the fulfilment of human potential will only be possible when issues of control over production and capital, and the class system, have been adequately addressed. These groupings within the feminist movement have evolved different goals, methods, and solutions, and have tended to apply themselves to different sets of problems.

Applied to counselling and psychotherapy, feminist core beliefs and values have resulted in a feminist approach to therapy built around four basic assumptions about women’s lives (Llewelyn and Osborne 1983):

- 1 Women are consistently in a position of deference to men. For example, women tend to have less power or status in the workplace. The leading feminist therapist Jean Baker Miller (1987) argued that women who seek to be powerful rather than passive are viewed as selfish, destructive, and unfeminine.
- 2 Women are expected to be aware of the feelings of others, and to supply emotional nurturing to others, especially men.
- 3 Women are expected to be ‘connected’ to, and controlled by, men, so that achieving autonomy is difficult.
- 4 The issue of sexuality is enormously problematic for women. This arises from a social context in which images of idealised women’s bodies are used to sell commodities, assertive female sexuality is threatening to many men, and sexual violence against women is widespread.

These statements map out a distinctive agenda for feminist therapy: these are not topics that are afforded any significant emphasis in mainstream theories of therapy such as psychodynamic, person-centred, or cognitive-behavioural. By contrast, feminism invites an awareness of social and economic realities, the meaning of the body, and the centrality of power in relationships that is quite unique within the counselling and psychotherapy world.



One of the first tasks of those women committed to putting a feminist agenda into action was to clear themselves a space, to show how and why the ways of doing therapy that prevailed in the 1960s and 1970s were inadequate.

### *The feminist critique of psychotherapy theory and practice*

Virtually all of the key historical figures in counselling and psychotherapy have been men, who have written, whether consciously or not, from a male perspective. Extensive efforts have been made by women writers and practitioners to envision theories and approaches in counselling and psychotherapy that are more consistent with the experiences and needs of women. Many of these efforts were inspired by the consolidation of feminism in the 1960s as a central force for social change. The work of feminist authors such as Simone de Beauvoir, Germaine Greer, Kate Millett, and others encouraged female psychologists and therapists to look again at established ideas in these disciplines. It would be mistaken to assume, however, that women had no voice at all in counselling and psychotherapy before that time. Within the psychoanalytic movement, Melanie Klein and Karen Horney had played a crucial role in emphasising the part of the mother in child development. Other women therapists, such as Laura Perls, Zerka Moreno, and Virginia Axline, had been important contributors to the founding of gestalt therapy, psychodrama, and client-centred therapy respectively, but had received much less attention than the men alongside whom they had worked.

The field of mental health affords multiple examples of the oppression and exploitation of women. There is ample evidence of experimentation on, and sexual abuse of, women clients and patients (Appignanesi 2008; Masson 1984; Showalter 1985). Studies of perceptions of mental health in women have shown that mental health workers view women in general as more neurotic and less well-adjusted than men (Broverman et al. 1970). The psychiatric and mental health professions, which provide the intellectual and institutional context for counselling and psychotherapy, can be seen to be no less sexist than any other sector of society. It is therefore necessary to recognise that the occurrence of patriarchal and sexist attitudes and practices in counselling and psychotherapy is not merely attributable to the mistaken ideas of individual theorists such as Freud, but has been part of the taken-for-granted background to most mental healthcare.

The evolution of feminist counselling and psychotherapy has involved a powerful re-examination of theoretical assumptions, particularly those of psychoanalysis, from a feminist point of view. Two of the fundamental ideas in psychoanalysis have received special attention: the concept of penis envy and the formulation of childhood sexuality. The notion of penis envy was used by Freud to explain the development of femininity in girls. Freud supposed that when a little girl first saw a penis, she would be 'overcome by envy' (Freud 1905/1977). As a result of this sense of inferiority, the girl would develop a motivation to look attractive to compensate for the missing penis, and a tendency to a less mature type of moral sensitivity due to the absence of castration anxiety, which Freud saw as such an important element in male moral development.

From a contemporary perspective, the penis envy hypothesis is incredible, ludicrous, and objectionable (Braun and Wilkinson 2001). However, such was the domination of Freud that this doctrine remained in force within the psychoanalytic movement for many years after his death (Howell 1981). It was only in the writings of Mitchell (1974) that a thorough critique of this aspect of Freudian theory was carried out.

It is possible to regard the penis envy hypothesis as an example of a lack of understanding of women in Freudian theory, an ill-conceived idea that can be reviewed and corrected without threat to the theory as a whole. The other main feminist objection to psychoanalysis is, however, much more fundamental. In the early years of psychoanalysis, Freud had worked with a number of women patients who had reported memories of distressing sexual experiences that had taken place in their childhood. Freud was uncertain how to interpret these memories, but in the end came to the conclusion that the childhood events that these women were reporting could not have taken place. It has been claimed, by Masson (1984) and others, that Freud, in the end, could not believe that middle-class, socially respectable men could engage in this kind of behaviour. Freud therefore interpreted

these reports as 'screen memories', or fantasies constructed to conceal the true nature of what had taken place, which was the acting out by the child of her own sexual motives. From a modern perspective, when so much more is known about the prevalence of child sexual abuse and the barriers of secrecy, collusion, and adult disbelief that confront child victims, the classical Freudian approach to this issue can be seen to be deeply mistaken. Masson (1984), one of the leading critics of this aspect of Freudian theory, was driven to label this set of ideas an 'assault on truth'. Like so many aspects of Freud's work, the truth about what actually happened in Freud's work with these patients is open to alternative interpretations (Esterson 1998, 2002). Nevertheless, the consequences of the position that Freud took (interpreting 'scenes of seduction' described by patients as fantasies) were to be far-reaching in terms of systematic professional denial of the reality of victims of abuse.

The feminist re-examination of psychoanalysis by Eichenbaum and Orbach (1982, 1984), Mitchell (1974), Taylor (1991), and others had the effect of opening up an intellectual, professional, and practical space within which distinctively feminist forms of therapy could be developed.

### *The emergence of feminist counselling and psychotherapy*

In one of the most influential early texts on feminist therapy, Worell and Remer (2002) encourage their readers to evolve their own 'feminist-compatible' model by examining the theory they presently employ in terms of the kinds of feminist principles and ideas discussed in this book. In effect, this approach constitutes a kind of feminist-informed integrationism. Worell and Remer (2002) suggest that a feminist approach should include:

- an egalitarian relationship with shared responsibility between counsellor and client; for example, being cautious about the imposition of interpretations on the client's experience;
- using a consciousness-raising approach; for example, differentiating between personal problems and political or social issues;
- helping women to explore and express their personal power;
- helping women to identify their internalised sex-role messages and beliefs, replace sex-role stereotyped beliefs with more self-enhancing self-talk, and develop a full range of behaviours that are freely chosen and not dictated by sex-role stereotypes;
- enabling women to understand that individual women's experiences are common to all women;
- helping women to get in touch with unexpressed anger;
- assisting women to define themselves apart from their role relationships to men, home, and children;
- encouraging women to nurture themselves as well as others;
- promoting skills development in areas such as assertiveness and employment;

Similar principles have been identified by Israeli and Santor (2000) in their analysis of 'effective components' of feminist therapy and by Hill and Ballou (1998) in a survey of feminist therapists. Examples of how these integrative principles can be applied in practice can be found in Brown (2009), Evans et al. (2010), and Tzou et al. (2012).

While many feminist counsellors and psychotherapists have followed Worell and Remer (2002) in integrating and adapting ideas and techniques from many therapy approaches to achieve feminist goals, others have sought to create a feminist version of psychodynamic psychotherapy. One group that has pursued this latter strategy consists of the network of practitioners associated with the Women's Therapy Centre (established in London in 1976) and the Women's Therapy Centre Training Institute (established in New York in 1981). These organisations have developed a form of feminist psychoanalytic/psychodynamic practice that is expressed in the writings of Luise Eichenbaum and Susie Orbach and their colleagues (Gutwill et al. 2010). An informative and accessible study of the experiences of women who have received therapy from the Women's Therapy Centre can be found in Morris (2005).

### Box 25.1: A feminist integrative approach to working with substance abuse

LaFave et al. (2008) used a combination of quantitative measures and qualitative interviews to evaluate treatment outcomes and perceived benefits of therapy in women with substance abuse problems who attended a feminist-oriented centre, 'A Woman's Place'. This report is of particular interest because it represents a flexible, integrative approach using feminist ideas alongside well-established substance abuse interventions such as motivational techniques and solution-focused therapy. The therapy programme that was on offer placed a strong emphasis on collaborative working and client empowerment. These therapeutic elements were reflected in the themes that emerged in interviews with clients at the end of therapy, who consistently mentioned the importance of the fact that the therapy they were offered gave them the opportunity to make their own choices and take responsibility for their own lives. What comes across very powerfully in this study is the extent to which feminist values made it possible for a team of counsellors to create an environment in which women were able to talk about the things that really concerned them, and actively expand their repertoire of coping strategies, rather than being passive recipients of a 'one-size-fits-all' treatment package.

#### *Relational-cultural therapy*

The group that has been most successful in articulating a specific feminist approach to therapy is the team based at the Stone Center and Jean Baker Miller Training Institute at Wellesley College, in Cambridge, Massachusetts, drawing on the work of key figures such as Miller (1976), Chodorow (1978), and Gilligan (1982).

The theoretical framework developed by Miller and her colleagues has sought to make sense of the psychological dimensions of the social inequality and powerlessness experienced by women through the use of a core concept of 'relatedness' or 'self-in-relation' (Miller 1976). In her study of gender differences in moral reasoning, for example, Gilligan (1982) found that, in general, men make moral judgements based on criteria of fairness and rights, whereas women assess moral dilemmas according to a sense of responsibility in relationships. The male way of looking at things, in Gilligan's (1982) words, 'protects separateness', whereas the female way 'sustains connections'. Gilligan goes on from this finding to suggest that men and women use different styles of constructing social reality: men fear intimacy, women fear isolation.

Miller (1976), Kaplan (1987), and other members of the Stone Center group have explored the implications of this 'relational' perspective for understanding patterns of development in childhood. They conclude that there is a basic difference between social development in boys and girls. For a girl, the relationship with the primary caretaker, the mother, is one of mutuality. Both are the same sex, both are engaged in, or preparing to be engaged in, the tasks of mothering and nurturing. For boys, the situation is one of achieving development and maturity only through increasing separation and autonomy from the mother. Men, as a result, are socialised into a separate, isolated way of being, and in counselling need help to understand and maintain relationships. Women, by contrast, spend their formative years in a world of relationships and connectedness, and in counselling seek help to achieve autonomy and also, crucially, to secure affirmation for their relatedness.

The approach to therapy that has emerged from this perspective on human development has been summarised by Jordan et al. (1991) and Jordan (2000) in terms of a set of core ideas:

- People grow through and towards relationships throughout the lifespan.
- Movement towards mutuality rather than movement towards separation characterises mature functioning.

- Relational differentiation and elaboration characterise growth.
- Mutual empathy and mutual empowerment are at the core of growth-fostering relationships.
- In growth-fostering relationships, all people contribute and grow or benefit – development is not a one-way street.
- Therapy relationships are characterised by a special kind of mutuality.
- Mutual empathy is the vehicle for change in therapy.
- Real engagement and therapeutic authenticity are necessary for the development of mutual empathy.

More recent work of the Stone Center group has emphasised the *cultural* as well as interpersonal aspects of the experience of ‘chronic disconnection’, in such arenas as racism, the workplace, and family life (Jordan et al. 2004).

The emphasis of the Stone Center on the *relational* nature of women’s development has led to a re-examination of some elements in the counselling process: empathy, mutuality, dependency, caring. Jordan (1991) points out that male-dominated therapy theory has tended to emphasise the goal of developing ‘ego strength’, defined in terms of strong boundaries between self and other. By contrast, the feminist notion of the relational self implies much more of a sense of interconnectedness between persons. This connection is maintained through a capacity to respond empathically to the other, and the concept of empathy is therefore a central element of the Stone Center approach. However, a distinctive aspect of the use of empathy within this approach to therapy is that it takes into account the empathic sensitivity of the client as well as that of the therapist. In the classical Rogerian ‘core conditions’ model, empathy is regarded as a therapist-supplied condition that can facilitate understanding and self-acceptance on the part of the client. In the Stone Center theory, empathy is viewed as a fundamental characteristic of women’s ways of knowing and relating. As a result, the client’s empathic engagement with others, including with the therapist, is one of the key areas for exploration in this form of practice (Jordan 1997a). In recent years, the approach to therapy that has originated from the Stone Center has become known as *relational-cultural therapy* (Walker and Rosen 2004), in an acknowledgement that effective practice requires attention to relationships within a cultural context.

Relational-cultural theory suggests that women are typically socialised into taking care of others, and participate in relationships in which they are empathic but receive little empathy in return. The experience of mutuality is therefore one of the areas that relational-cultural therapy seeks to examine. Jordan (1991) has argued intersubjective mutuality provides an opportunity to extend our understanding of the other and, through this, achieve an enhanced awareness of self.

One of the key goals of this type of therapy is to enable the client to participate in relationships marked by high levels of mutuality. Mutuality is also expressed in the therapy relationship itself, with feminist therapists being willing to be ‘real’, self-disclosing, and actively helpful in the therapy room (Jordan 2000). That mutuality, based on the therapist’s willingness to let the client see how they are affected by what the client is going through, helps the client to develop a realistic awareness of the impact of their actions and words on other people and on relationships (Jordan 2000).

The theme of connectedness in relational-cultural theory is also applied through a reappraisal of the concept of dependency. In the counselling and psychotherapy literature as a whole, this quality is generally considered to reflect an inability on the part of the person to take adequate control of their own life. Many men find dependency threatening to their self-esteem (Stiver 1991a). From a feminist perspective, however, dependency is a basic aspect of everyday experience. The fact that it is often pathologised by mental health professionals can be seen as another example of the dominance of patriarchal attitudes. In an effort to highlight the life-enhancing and constructive aspects of dependency, Stiver (1991a) redefines ‘dependency’ as a willingness to seek help and support from other people, and adds that this process has the potential to build personal well-being, self-esteem, growth and, development.

Stiver (1991b) draws out some of the implications for counselling and psychotherapy practice of a relational-cultural perspective on the concept of care. For her, traditional psychodynamic approaches to counselling and psychotherapy have been based on a principle of establishing relational distance between counsellor and client, in order to promote objectivity. Stiver argues that this is essentially a masculine model, which does not work well for women (or for some men), and proposes that therapists should be willing to demonstrate that they care about their clients, that they express 'an emotional investment in the other person's well-being' (Stiver 1991b: 265).

This is a necessarily oversimplified account of a complex and powerful theoretical model. Nevertheless, it can be seen that it points the way towards a distinctive approach to feminist therapy. Relational-cultural theory places a psychodynamic theory of development alongside a person-centred understanding of the therapeutic relationship, but has reinterpreted both sets of ideas from a feminist perspective that looks at therapy as part of a social and cultural environment characterised by male domination. The notion of the relational, connected self serves as a way of effectively bridging these theoretical domains. The relational-cultural model has also been used to construct an analysis of the ways that women mask their power and anger (Miller 1991a, 1991b), and to develop a model of women's depression (Stiver and Miller 1997).

Another important theme running through the work of this group has been an appreciation of women's problems in the world of work, in environments where mutual, empathic, caring relationships are difficult to sustain. Recent writings have focused on the application of the model to ethnic minority and lesbian women (Jordan 1997b), substance abuse, therapy in prisons, and group therapy (Walker and Rosen 2004), the dynamics of power in relationships (Jordan 2008), self-injury (Trepal 2010), schools counselling (Tucker et al. 2011), and eating disorders (Trepal et al. 2012).

## Box 25.2: A feminist approach to depression

From a feminist perspective, depression can be understood as a form of silencing, through which women's responses to oppressive social practices are suppressed (Jack 1991; Jack and Ali 2010). There are two therapeutic principles that have informed feminist counselling for depression. The first is to use women as a guide to what might be useful, rather than rely on general theoretical models. An example of using women as a guide is a study by Wilson and Giddings (2010), which collected women's stories of recovery from depression as a means of building a framework for counselling practice. The second therapeutic principle is to recognise that overcoming depression requires practical action (in relation to issues such as housing, employment, debt, education, parenting, and domestic violence) as well as psychological insight. An example of a feminist approach to depression that combines practical action alongside personal development is the Feminist Relational Advocacy project (Goodman et al. 2009), in which low-income women who were depressed were paired with counsellor-advocates. The findings of this study provide substantial evidence for the view that internalised oppression and external oppression are inextricably interlinked, and that moving on from depression requires attention to both simultaneously.

### *The development of a feminist ethics for therapy practice*

The practice of feminist counselling or psychotherapy involves the practitioner in acting not only from a therapeutic standpoint, but also espousing a set of values and a political agenda. This position has led most feminist counsellors to be highly aware of the ethical dilemmas arising from their work:

- Critics of feminism may accuse feminist practitioners of misusing the therapeutic relationship to promote feminist ideology or recruit members for feminist organisations.



- The political dimension of feminism makes women aware of power inequalities in general, but specifically the power difference inherent in any client–counsellor relationship.
- Feminist counsellors and psychotherapists and their clients may be drawn from relatively small communities of like-minded women, leading to greater possibilities for potentially destructive dual relationships.
- Women’s moral decision-making makes use of intuition and feeling as well as logical analysis, and takes account of how moral actions have an impact on relationships. As a result, there are times when ethical codes and guidelines formulated from a male perspective may not be wholly appropriate to feminist practice.
- There are occasions when the emphasis in feminist theory on mutuality and the existence of a genuine, transparent relationship between counsellor and client can contribute to a lack of clarity in therapeutic boundaries.

These factors, which map out a significant area of difference between feminist practice and mainstream thinking, have stimulated considerable debate within the feminist therapy literature.

It is important to note here that feminist counselling and psychotherapy has largely evolved in isolation from mainstream organisational and institutional settings. For many feminists, the office blocks of professional power and authority represent patriarchal structures to be subverted and opposed.

Feminist counsellors and psychotherapists have addressed ethical issues in two ways. Much feminist therapy takes place in the context of ‘collective’ feminist organisations, such as women’s therapy centres or rape crisis centres. Typically, members of these organisations are well aware of moral and ethical dilemmas associated with feminist practice, and set up effective mechanisms for reviewing the operation of their agency in the light of such issues. In addition, there have been some attempts to create feminist ethical codes (see, for example, Rave and Larsen 1995).

### Box 25.3: Becoming a feminist therapist

There are few training programmes in feminist counselling and psychotherapy, and feminist ideas tend to be ignored or given scant respect in most training institutes and courses. It is therefore difficult for beginning counsellors and psychotherapists who find meaning in feminist perspectives to obtain the support and guidance that is required in order to develop an identity as feminist practitioners. Horne et al. (2001) and Kannan and Levitt (2009) analysed the personal accounts of counselling and psychotherapy trainees who identified as feminist. Key themes in these stories are the experience of isolation and a lack of information, as well as the importance of finding a mentor, not only as a role model but also to act as a buffer against hostile anti-feminist remarks from colleagues and tutors. Valuable accounts of the process of becoming a feminist therapist, and the implications of this stance for career and relationships, have been written by two highly influential figures in the feminist therapy movement: Laura Brown (2013) and Iris Fodor (2001, 2010).

### *The contribution of feminism to counselling and psychotherapy*

Feminist therapy is an approach that fundamentally transforms, subverts, and radicalises therapy, by placing practice firmly and explicitly within a context of social action and change. The progress of feminist counselling and psychotherapy over the past 40 years has been impressive, given the fact that it represents a radical perspective that is not likely to find any special favour in male-dominated universities and government agencies. There has been an explosion of new ideas and methods, books,



and applications of feminist approaches to different client groups. Feminist practitioners have been in the vanguard of the movement to make therapy more socially aware and user-friendly. Feminist theory has provided a philosophical, historical, and social meta-theory or meta-perspective that has enabled feminist therapy to move beyond a purely psychological, individualised view of the person. This has provided feminist therapists with a constant source of ideas and energy: as the political struggle has moved on to new issues and contexts, therapy has followed. Many therapists (including male therapists) have been profoundly influenced by these ideas and principles.

Alongside the ways in which feminist ideas have contributed to the development of a distinctive and influential approach to therapy, has been the emergence of specialist services intended to address the personal problems of women. Because such services have been informed by feminist political movements, they have been critical of the limitations of regular mainstream treatment provision. Making women's issues 'visible' and worthy of attention was a crucial first important step in the creation of services such as shelters for abused women, therapeutic support for rape victims, and support centres for women engaged in sex trafficking and prostitution, and for women and children exposed to sexual abuse.

## Therapy for heterosexual men

The experience of counselling and psychotherapy agencies and clinicians in private practice, along with evidence from many research studies, indicates that heterosexual men are less likely than any other group to seek therapeutic help for psychological problems. Instead, male coping strategies tend to include such activities as denial, being busy at work, self-medication through alcohol and other substances, risk-taking, violence to self and others, pornography, lack of self-care up to the point of developing serious illness such as heart disease, and suicide. On the other hand, there is also plentiful evidence that, once they engage with therapy, heterosexual men have the potential to get just as much out of it as anyone else.

There is no particular reason why men *should* make use of therapy, if their other methods of dealing with relationship and emotional difficulties are effective. However, there is a general acknowledgement that there is a crisis around men's mental health, arising from prevailing patterns of social and cultural change. Historically, most (but not all) cultures have been characterised by fairly rigid separation of gender roles. Women have looked after children and the home, and men have worked outside the home, fought wars, and have been expected to be rational, brave, and self-sufficient. In North American and European societies, and then at a global level, this set of arrangements gradually fragmented during the latter half of the twentieth century. Women went out to work, attaining leading roles in previously male professions such as medicine, law, politics, and the clergy. Women took on frontline roles in the armed forces and police. Men were expected to do their share of the housework and childcare. Levant (2011) and others have described this as an era of ever-increasing masculine gender role strain. Basically, traditional forms of masculinity have become increasingly dysfunctional in a post-industrial age. In response, there has emerged a steady stream of ideas and initiatives around how to adapt counselling and psychotherapy theory and practice so that it could be more responsive to the concerns of men (see, for example, Brooks 2010; Duffey and Haberstroh 2013; Englar-Carlson and Stevens 2006; Englar-Carlson and Kiselica 2013; Good and Brooks 2005; Oren and Oren 2010; Rabinowitz and Cochran 2002; Sweet 2012; Wexler 2009; Yeazel 2015).

Unlike therapy for women, the field of therapy for men has not, to date, coalesced around a specific set of principles or single theoretical approach. Englar-Carlson and Kiselica (2013) suggest that what men need is therapy that offers a vision of positive masculinity in which traditional male virtues are both challenged and adapted in relation to their applicability in a postmodern world. Among the topics that may need to be addressed in therapy with heterosexual men are: learning how and when to express emotions and ask for help; promoting male ways of relating and caring, including generative fatherhood; acknowledging the importance of work, courage, heroism, and humour; developing supportive relationships with other men.

Other examples of adaptations of mainstream therapy that take account of male ways of being can be found in counselling services that are attached to male-dominated occupations such as the armed forces, police, fire service, and some sports. Examples of this kind of development can be found in innovative ways of working with trauma and PTSD in such occupational contexts. There are also services targeted at men that have been created within fields such as drug and alcohol addiction, internet pornography, child sexual abuse, suicide, and prison populations. A later section in this chapter examines counselling and psychotherapy for men who are perpetrators of domestic and sexual violence.



### Case study 25.1: The case of Jesse

Jesse was a youthful-looking 53-year-old white man who joined a weekly men's therapy group because he feared the impending break-up of his second marriage, and was looking for male support. He was the father of a 7-year-old boy, with whom he shared custody with his ex-wife. In the group, Jesse came across as charming and articulate, responding with curiosity and interest to the experiences shared by other members.

To create a process through which men could explore important life themes, each session of the group began with the facilitators introducing an issue. For example, participants might be invited to pair up and talk, in turn, about an occasion when they felt out of control. Other activities involved talking about the experience of betraying personal values, or how their approach to life had been influenced by their relationship with their father.

Although he actively participated in the group, Jesse was evasive when asked to talk about his own life. Several months into the group, he missed a session. One of the co-therapists contacted him at home and was told by his wife that Jesse was in a psychiatric hospital, having attempted suicide. It became apparent that, behind a competent façade, Jesse was extremely troubled and depressed. In addition to marital troubles, he had been diagnosed with cancer and was facing a sexual harassment complaint at work. He had effectively masked his depression in the group and in individual meetings with the group therapists.

Following his re-entry to the group, Jesse talked more openly about his experience of growing up with a father who was a career military officer, absent for long periods of time and committed to a living according to a traditional masculine ideology, intolerant of neediness and vulnerability, and Jesse's struggle to build an alternative masculine identity for himself. Over time, Jesse became more able to accept care and support from other members of the group, and was able to negotiate his way through a second divorce. The authors of this case report, Rabinowitz and Cochrane (2008), suggest that Jesse represented a typical male pattern of suppressing feeling, avoiding asking for help, a controlling and angry domestic self, and eventual use of violence against the self as a desperate solution. They were critical of their own failure, as specialists in therapy with men, to be aware of, and challenge, the strategies that Jesse used to hide his depression.

## Gender and sexual diversity

Following Davies and Barker (2015), the term 'gender and sexual diversity' is a way of summarising what is often referred to as 'LGBTQ+ . . .' (lesbian, gay, bisexual, transgender, intersex, queer, questioning, BDSM/Kink, nonbinary, asexual, consensual non-monogamous, and other diverse sexualities and practices). This form of words reflects a position of acceptance that gender and sexuality exist on a spectrum and that individuals can move around on that spectrum, rather than being

limited to a set of fixed binary categories (male/female; heterosexual/homosexual). In addition, it further reflects the fact that sexual orientation and gender identity interact and combine with each other, and with ethnicity, social class, age, and personal circumstances, to produce 'intersecting identities' (Das Nair and Butler 2012; Richards et al. 2016). From this starting point, the issue becomes that of developing therapy theory and practice in ways that are responsive to gender and sexual diversity expressed and lived by each individual.

A key element with gender and sexual diversity therapy is that of how to address the fact that this kind of diversity is not acceptable in many societies, or has only recently become acceptable, and that persons who experience themselves as gender diverse may be subject to cultural oppression and even legal sanction. The social world in which therapy has developed over the past century is a world marked by a high degree of homophobia. Many societies enforce laws that restrict or criminalise homosexual behaviour, and there is widespread stigmatisation of gay and lesbian relationships even in societies where such behaviour is legal, despite the fact that around 10 per cent of the population is homosexual. Although gay and lesbian clients in therapy will seek help for the same wide range of general relationship, self-esteem, and stress problems felt by heterosexual people, there are some distinctive issues that may be presented by clients from this group. These include dilemmas and anxieties about the process of 'coming out' and accepting a gay, lesbian, or other diversity identity, and the stress of coping with everyday microaggression and negative discrimination. There may be additional problems for the heterosexual therapist of being aware of their own possible homophobia, and achieving an understanding of the language and norms of relevant gender and sexual diversity subcultures. These are themes that have been identified in qualitative research that interviewed individuals who identify as gender and sexually diverse (Adams et al. 2013; Elder 2016; Singh et al. 2014) and mental health practitioners working with LGBTQ clients (Bond et al. 2017).

A vital task for therapists is to be aware of the history of hostility directed by the mental health professions to gay, lesbian, and other sexually diverse individuals. It was only in 1974 that homosexuality ceased to be classified as a psychiatric disorder by the American Psychiatric Association (Bayer 1987). Those who opposed this change included psychoanalysts and psychotherapists as well as 'medical model' psychiatrists. The founder of rational emotive therapy, Albert Ellis, was also in the 1950s a proponent of the view that exclusive homosexuality was a neurotic disorder that could be resolved through effective psychotherapy (Bayer 1987). Eventually, the American Psychological Association (APA) responded to initiatives from its membership by becoming involved in various campaigns to support the rights of gay men, bisexual men and women, and lesbians, and presenting legal evidence in several court cases to the effect that homosexuality is not an illness (Herek et al. 1991). In 1984, the APA set up a task force to investigate bias in psychotherapy with lesbians and gay men. The task force surveyed a large number of psychologists concerning specific instances of biased and sensitive practice. Respondents in the survey described many incidents that they had experienced personally, or that had been reported to them by clients, that exemplified anti-homosexual attitudes (Garnets et al. 1991). Although this evidence provided a platform for the production of guidelines that had the effect of bringing about a shift in professional attitudes, there is still some way to go, such as in respect of the legality and ethical acceptability of sexual orientation conversion therapy (Drescher et al. 2016; McGeorge et al. 2017).

For many years, mainstream counselling and psychotherapy research largely ignored the existence or needs of non-heterosexual clients. Even research articles that were published were written in a manner that lacked respect for people who are gender diverse. In 1991, the APA found it necessary to publish guidelines for 'avoiding heterosexist bias' in research (Herek et al. 1991). As a result, in a systematic review of research into affirmative therapy with LGBT clients, King et al. (2007) were only able to identify 22 good-quality studies. Only within the past decade has it been possible to build an evidence base for therapy practice with persons who espouse gender and sexually diverse ways of living.

To counteract negative societal attitudes, including destructive beliefs that may have been internalised, it is essential for therapists working with gay men, lesbians, bisexual people, and those

identifying with other gendered identities, to operate from an 'affirmative' stance towards their clients (Johnson 2012; Walsh and Hope 2010). The aim is to reinforce and celebrate the validity and acceptability of the whole spectrum of gender and sexual behaviour and relationships. To accomplish this, it is often necessary to challenge the homophobic or other negative attitudes that the client has internalised through socialisation. The provision of accurate information about gender and sexual diversity can often be a part of this process, as can sensitive rehearsal with the therapist of how the client will tell others about their sexuality or their decision to come out. Part of this process may draw on practices of resistance within people who express diverse sexualities and gender identities. For example, the re-appropriation by this community (and others) of the word 'queer' reflects an intentional act of political resistance to a dominant 'heteronormative' society: the concept of 'queer-ness' encompasses all forms of 'deviant' sexuality, from bondage to asexuality.

Some therapists working with gay and lesbian clients have adopted a developmental approach, viewing the experience of 'coming out' as a set of developmental tasks. The model of coming out originally constructed by Coleman (1982) postulates five developmental stages in the coming-out process: precoming out, coming out, exploration, first relationships, and integration. Other issues that are often present in therapy with people who are gender or sexually diverse include: the traumatising effects of exposure to homophobic attitudes, behaviour, and violence; internalised homophobia; relationships and marriage; family conflicts; sexual problems; attitudes to ageing; and coping with AIDS/HIV. An important theme within this literature is the idea that effective therapy requires social empowerment as well as work on individual issues (Savage et al. 2005). The development of theory, research, and practice in this area of therapy is discussed by Kort (2008), Langdridge (2007), Moon (2008), and Pachankis and Goldfried (2004). Therapists working with gender and sexual diversity need to explore their own attitudes and values around these topics, and engage in training and supervision to enable the development of appropriate knowledge and competencies (Coyle et al. 1999; Davies and Barker 2015; Matthews et al. 2005; Pillai-Friedman et al. 2015).

The counselling and psychotherapy needs and concerns of transgender individuals are particularly complex, typically encompassing surgical interventions over a period of time, dealing with social attitudes, and coping with identity issues (Bidell 2016; Fraser 2009). The co-existence of these pressures means that transgender people represent a distinctively vulnerable group of clients (Hunt 2014).

Accessible, brief, and moving explorations of issues explored in this section can be found in papers by an American gay therapist, Douglas Haldeman (2010), in which he reflects on the experiences over the course of his career as a gay practitioner, and the accounts by Speciale et al. (2015) of what it was like for them to be diversely gendered students on a counsellor training programme.

### Box 25.4: Experiences of gender and sexually diverse individuals in therapy

There is evidence that LGBQ people are more likely than heterosexual people to make use of therapy during their lifetime (Eubanks-Carter et al. 2005). Despite this, several research studies have documented negative experiences of gender and sexually diverse individuals in therapy. For example, in interviews with LGBQ individuals who had received therapy, Shelton and Delgado-Romero (2011) identified several subtle ways in which the gender/sexual position of the client was attacked (microaggressions): avoidance and minimising of sexual orientation; attempts to over-identify with LGBQ clients; the therapist changing the way they spoke or changing their physical posture to appear more comfortable with LGBQ individuals; making stereotypical assumptions; assuming that all LGBQ people are alike; expressing heteronormative bias; describing the client as abnormal; assuming that all LGBQ individuals need psychotherapeutic treatment; encouraging a client to stay in treatment against the client's wishes; warnings about the dangers of identifying as LGBQ. Similar

themes were reported by Mizock and Lundquist (2016) in a study of the therapy experiences of transgender clients. In an earlier study by Liddle (1996), even though the therapy experiences of the gay and lesbian clients were positive overall, there was still a significant minority who stated that their therapist pressurised them to renounce their homosexuality, or even terminated therapy once the client had disclosed their sexual orientation. Liddle (1997) observed that 63 per cent of gay and lesbian clients screened their therapist for gay-affirmative attitudes before committing themselves to therapy, and that the majority had a strong preference for a therapist with a similar sexual orientation. Studies by Liddle (1995, 1996, 1997), Annesley and Coyle (1998), Evans and Barker (2010), and Ryden and Loewenthal (2001) found that many gay and lesbian consumers of therapy are aware that they need to be careful about which therapist they choose.

### Box 25.5: Negative attitudes of therapists to gender and sexual diversity

A survey among British psychoanalytic psychotherapists (Bartlett et al. 2001; Phillips et al. 2001) used a combination of questionnaires and in-depth interviews to explore the attitudes of a group of experienced and highly qualified practitioners to working with gay and lesbian clients. A postal questionnaire was sent to 400 randomly selected members of the British Confederation of Psychotherapists, with completed questionnaires being received from 218 respondents (a 55 per cent response rate). The questionnaire asked whether the respondent would be willing to be interviewed: 33 indicated a willingness to do so, of whom 15 were interviewed.

The data collected in this study revealed that there were issues for many of these therapists around acceptance of gay and lesbian experience. Many of the therapists in the study reported that they believed that their training organisation would not accept gay or lesbian people for psychotherapy training, and that gay or lesbian trainees or members of the organisation kept their sexual orientation secret (Phillips et al. 2001). The majority of the therapists who were interviewed said that they knew of colleagues, whom they regarded as suitable for training, who had been refused a place on the grounds of sexuality. Some research participants admitted that they personally agreed with the policy of excluding gay men and lesbians from psychotherapy training.

## Therapy for sexual concerns

Sexual behaviour and the expression of sexuality represent pivotal aspects of the lived experience of gender. The sexual act, and the activities that precede and follow it, are events that carry huge psychological and cultural meaning. It is an act that usually takes place in private and which has implications for fundamental social institutions such as marriage, family, and being a parent. It is the physically closest that two or more people can normally be – a merging of bodies. Further layers of meaning exist around themes of desire, desirability, attractiveness, shame, guilt, pleasure, pain, and joy.

In Christian Europe, it was not that long ago that individuals would have been publicly condemned in church for engaging in the wrong type of sex. There are still places in the world where people can be publicly flogged or stoned, or put to death (so-called ‘honour killings’), for offences against sexual rules and laws.

Many people spend a lot of time ruminating and worrying about their sexual attractiveness and performance, particularly in adolescence and early adulthood, but also through later stages in the



life course. They invest time and money on fashion, diets, fitness regimes, books, magazines, and medications to buttress their sexual confidence and competence.

It is to be expected that it is likely such a highly significant and meaningful dimension of life would be implicated in many of the difficulties and concerns that lead people to seek help from a therapist. A major aspect of the cultural impact of psychoanalysis was that it provided a place where people were allowed to talk about themselves as sexual beings, and how their experience and expression of sexuality lay behind their more overt problems in living exhibited in symptoms such as anxiety, depression, compulsions, and obsessions.

There are two main ways in which sexual concerns may be addressed in counselling and psychotherapy. The person may talk about these concerns in the context of routine therapy. Or, they may seek out, or be referred to, a specialist sex therapist.

Sex therapy is generally understood as comprising a set of interventions within the broader field of couple and marital therapy. Sexual issues are usually connected to relationship difficulties of one type or another, and it does not make sense to try to sort out sexual problems if solutions are being undermined by relationship issues such as interpersonal hostility or a failure to communicate. Sex therapy focuses on areas of sexual dysfunction such as incompatible sexual preferences, painful sex, lack of desire, erectile failure, and premature ejaculation. Many of the techniques used in sex therapy draw on ideas and methods from cognitive-behavioural therapy, in terms of strategies for learning and practising new behaviours, scaling back harshly self-critical cognitions, replacing irrational beliefs with evidence-based knowledge, and developing and applying appropriate assertiveness and communication skills. Further information about the principles and practice of contemporary sex therapy can be found in Barker (2011), Berry and Lezos (2017), Kleinplatz (2012), and Richards and Barker (2013), and in the journal *Sexual and Marital Therapy*. Sex therapy can be highly effective if clients are ready for it (i.e. have sufficiently dealt with emotional and relationship barriers to engagement in good sex). If sex therapy gets off to a good start, then clients can quite quickly enter a positive self-reinforcing cycle of learning and change.

Routinely, there are many sexual concerns that the person may wish to talk about but fall outside the remit of sex therapy. Areas of concern may include: fears and anxieties arising from experiences of sexual abuse and assault; inhibition fuelled by negative messages about sex; negotiating frequency, asking and saying no; use of pornography, masturbation, sex aids, drugs, alcohol, medication, etc.; wanting sex with the 'wrong' person; changes in sexuality caused by illness, pregnancy, or ageing. These issues can be regarded as normal questions and challenges associated with healthy sexuality or what is increasingly described as 'sex positivity' (Burnes et al. 2017a; Mosher 2017). They may also represent areas where sexual behaviour and choices are inextricably part of other issues that are being explored in therapy. For example, any of these concerns could be part of the experience of depression or the effort to find meaning in life.

There are many factors that make it hard for clients in therapy to talk about their sexual concerns. For many individuals, this is a highly private and secret area of experience, which has rarely, if ever, been discussed with anyone. It may seem a betrayal to a spouse or partner to talk to a stranger about such intimate aspects of a relationship to anyone else. The words and language that the person uses to talk about sex may be idiosyncratic, culturally specific, or too rude to use in a professional consultation. The topic may be a source of embarrassment or shame. Important aspects of sexuality may be bound in private fantasies. There is research evidence that clients frequently lie to their therapists about sexual concerns, and that in many instances this undermines the effectiveness of therapy (Blanchard and Farber 2016; Farber et al. 2018). In a valuable discussion of the difficulties that clients encounter when wanting to talk about sexual concerns to their therapist, Love and Farber (2017) suggest that the majority of clients prefer the therapist to take the initiative and ask them directly whether they have such issues, and whether they want to explore them in therapy.

For many therapists, it can also be hard to facilitate, or participate in, therapeutic conversations about sexual concerns. A survey of clinical psychologists in the USA found that 60 per cent never or infrequently asked clients if they had sexual concerns (Reissing and Giulio 2010). A review of the



adequacy of coverage of sexuality issues in counselling and psychotherapy training programmes indicates that most training providers acknowledge that more attention should be devoted to this topic (Burnes et al. 2017b). Many therapists describe themselves as uncomfortable around sexual issues (Anderson 1986; Harris and Hays 2008; Miller and Byers 2008). Guidelines for therapists around how to approach sexuality topics in therapy can be found in Findlay (2012) and Cruz et al. (2017).

One of the most difficult facets of addressing sexuality in therapy is associated with erotic transference (the client having sexual feelings towards the therapist) and countertransference (the therapist having sexual feelings towards the client). These processes occur quite often (Sonne and Jochai 2014) and can be viewed as representing an inevitable consequence of the intensity of a therapeutic relationship. Many therapists are troubled by such situations and report dilemmas around how to respond (Rodgers 2011). On the one hand, denying or discounting what is being felt may be wounding to the client. On the other hand, acknowledgement and acceptance may be seen as opening the door to a celebration of positive sexuality, or to an unethical and unhelpful sexual relationship between therapist and client (Goren 2017; Stirzaker 2000). It is likely that, for some therapists, the awfulness and potential risk of getting anywhere close to erotic transference or countertransference may be a factor in avoiding or closing down any discussion of sexuality at all. A more constructive response involves exploring the meaning of client–therapist sexual desire in terms of issues within the therapeutic relationship, or within the personal worlds of either the client or therapist (Capawana 2016; Celenza 2007, 2010; Gelso et al. 2014; Lotterman 2014).

In conclusion, the exploration of sexual experiences, concerns, and issues in generic therapy is important, but is often hard to accomplish, and its absence can significantly diminish the effectiveness of therapy for some clients. There is an increasing appreciation with the counselling and psychotherapy professions that more training, supervision, and research are needed around this topic, and that it has not been helpful for frontline therapists to regard it as the sole business of specialist sex therapists. The concept of sexual positivity, which approaches sexuality from a strengths and positive psychology perspective, has emerged as a potentially valuable way forward.

## Abusive sexuality

There are many ways in which sexuality is associated with violence, cruelty, and evil: sexual harassment, microaggression, rape, sexual abuse, domestic abuse, prostitution, trafficking, addiction to internet pornography, female genital mutilation, forced marriage, voyeurism, paedophilia, forced participation in pornography, stalking, blackmail, bullying, kidnap and imprisonment, murder. While these acts may be motivated by political ideology, religious dogma, and individual psychopathology, they represent ways in which dark forces are channelled into sexuality.

The phenomenon of abusive sexuality is relevant for therapy in several ways. At a general level, it is not adequate to regard internalised fear and inhibition around sexuality, expressed by many therapy clients, as an irrational response (e.g. catastrophising) that merely reflects faulty cognitive learning on the part of the individual – there are significant real-world risks that need to be taken into account. For example, while a young female client may be helped by therapy to express her sexuality, she still needs to be aware of the possibility of date rape. In addition, it can be hard to draw a line between positive and abusive sexuality. For example, in some situations sex work, pornography, or bondage can be life-enhancing and in other situations they can be destructive.

A further consideration for therapists is that, while many instances of abusive sexuality can be regarded as traumatic events, it seems to be helpful to view them as different from types of trauma that are less personally intimate. Post-traumatic stress disorder can occur following events such as being in a road traffic accident or experiencing the sudden loss of a loved one. By contrast, abusive sexuality is an act that has been purposively inflicted by another person. Moreover, that person is often someone with whom the victim is in a pre-existing close relationship, such as a family member, priest, or teacher. Gómez et al. (2016) believe that it can be useful to view sexual violence as *betrayal trauma* – an event that shatters connections and trust. They suggest that relational cultural therapy

is an appropriate therapy approach for addressing betrayal trauma because of its emphasis on repairing connections through authentic relating. There can also be an existential dimension to therapy with victims/survivors of abusive sexuality, in the sense that what they experienced has been a threat to their right to be, or an attack on their core self. An additional challenge in this kind of work is the fact that the person almost certainly continues to live in a sexist and homophobic society that is permeated by constant, low-key reminders of negative and exploitative attitudes towards sexuality.

One of the most problematic aspects of the role of therapy around the topic of abusive sexuality is attempts to bring about behaviour change and rehabilitation in perpetrators and offenders. This kind of therapy is extremely difficult because clients may have been mandated through court order to attend, may be unable or unwilling to accept that they have done anything wrong ('she asked for it'), or may be vaguely aware that their self-concept would fracture if they were to reach a point of genuinely admitting responsibility. Some therapists find it difficult to accept such clients and to develop productive therapeutic alliances with them.

## Conclusions

In therapy, gender and sexuality are topics that are hidden in plain sight. Everyone who has ever been in therapy remembers the presenting gender of their therapist, even if they do not recall their name or how often they met. Given the chance to talk about the significance of having a same-sex or other-sex therapist, therapy clients are able to talk at length about the pros and cons of these arrangements in terms of their own personal experience (Gehart and Lyle 2001; Kastrani et al. 2015). Yet gender is not an aspect of human existence that is specifically addressed in most theories of therapy, and is given little attention in training and research, relative to other topics. Similarly, sexual preferences, choices, and activities are hugely significant to individuals, but seldom discussed in therapy.

This chapter has attempted to establish three main points about the place of gender and sexuality in counselling and psychotherapy theory and practice. First, gender and sexuality are important and so require attention. Therapists tend, understandably, to be hesitant and lacking in confidence around this aspect of practice and need more support. Second, the gradual emergence of an appreciation and acceptance of gender and sexual diversity has had a catalytic impact on the field as a whole, in challenging the use of binary distinctions and permitting thinking in terms of multiple gender identities and forms of sexual behaviour. This has resulted in a shift in therapist attitudes to 'hetero' sexuality, exemplified by the increasing use of the concept of sexual positivity. Third, no progress can be made without serious consideration of factors external to the individual: economic, political, and technological. Both multinational corporations and a variety of local entrepreneurs make a profit from sex and from gender role insecurity. These companies and individuals are not interested, on the whole, in sexual positivity. This domain of economic activity is becoming more intense and impactful, in the form of cybersex addiction and sex robots. As with feminist therapy, any therapist with interests in the area of gender and sexuality needs to realise that effective gender-informed therapy depends on an active commitment to social justice.



### Topics for reflection and discussion

- 1 From the perspective of being a client or therapist (or both), what has been your experience of gender and sexuality as factors in the client–therapist relationship?
- 2 With respect to yourself as a therapist, or other therapists you know, to what extent and in what ways are you (or they) more/less effective with male and female clients? How do you make sense of these differences in effectiveness?

- 3 How important has gender and sexuality been in relation to the issues and problems that you have worked on in your own therapy? What kinds of therapeutic processes have been most helpful for you in resolving these issues?
- 4 What are the implications of feminist ideas for male therapists and clients? To what extent is feminist therapy only appropriate or helpful for women who already hold feminist beliefs? Does feminist therapy necessarily imply conversion to a feminist way of thinking?
- 5 How open are you to conversations around sexual orientation and sexual preferences?

## Suggestions for further reading

The journals *Women and Therapy*, *Psychology and Sexuality*, and *Psychology of Men and Masculinity* are reliable sources of information on current trends in the areas of counselling and psychotherapy discussed in the present chapter. Also recommended are *Gender in the Therapy Hour* (Sweet 2012) and *Sexuality and Gender for Mental Health Professionals: A Practical Guide* (Richards and Barker 2013).

# Chapter 26

## A social justice orientation: therapy as political action

<b>Introduction</b>	<b>395</b>
<b>Social justice as an overarching aim of therapy</b>	<b>396</b>
<b>Being and becoming a social justice-oriented therapist</b>	<b>397</b>
The concept of power	397
The concept of justice	398
Models of social justice therapy practice	399
Self-awareness and training	399
<b>Social justice therapy in action</b>	<b>400</b>
<b>Social action research</b>	<b>404</b>
<b>Conclusions</b>	<b>405</b>
<b>Topics for reflection and discussion</b>	<b>405</b>
<b>Suggested further reading</b>	<b>406</b>

### Introduction

At the heart of counselling and psychotherapy is the one-to-one relationship between a therapist and a person who is troubled to the extent that they are unable to live a satisfying life. The task of the therapist is to work on behalf of their client to help them to accomplish their goals, whatever these goals might be. Essentially, this is an individualised perspective – the person can be assisted through attention to their individual psychological and neurobiological functioning, with little or no reference to social conditions. Although many therapists operate on the basis of an individualised approach of this type, there is a growing appreciation that it does not represent a sufficient basis on which to proceed. Clients describe many different types of adversity that they have had to face: racism, sexism, homophobia, microaggression, bullying, violence, and so on. While assisting the individual person to become more resilient, resourceful, accepting, and forgiving is certainly worthwhile, it does little to stop any of these things happening again and again. Many therapists also have

concerns over the deeper meaning of their role: they did not become therapists to help others to become happy consumers or obedient workers.

In recent years, these issues have coalesced around the concept of *social justice*. A social justice orientation to therapy originally emerged from the multicultural tradition in therapy but has subsequently developed as a distinctive form of practice in its own right (Audet and Paré 2018; Chung and Bemak 2012; Ibrahim and Heuer 2016; Nwoye 2010). It became obvious to many therapists that the issues faced by clients from minority backgrounds were inextricably linked to social inequality and political oppression, and could not be addressed in a satisfactory way without taking the socio-political dimension into account, including empowering clients to initiate social change. Gradually, the value of a social justice perspective has become apparent in all areas of therapy practice.

A commitment to social justice is about making the world a better place, in terms of greater equality, respect, and opportunity. It has a preventative function – not just helping people to cope with adversity, but having a stake in reducing or eliminating the causes of adversity. The notion of *critical consciousness* is an important theme: therapy can enable people to reflect not only on their own life history but on the way that power and control are exerted by particular groups in society. In some circumstances, social justice may mean advocating and campaigning on behalf of individual clients, groups, and communities.

Social justice encompasses *sustainability*: a commitment to the natural environment and other life forms and to living within our means. Most of the literature and activity around social justice has focused on issues around poverty, and violence and discrimination against different social groups. Sustainability brings a future dimension into these initiatives. Without sustainable lifestyles, we are denying social justice to our children and grandchildren.

The social and cultural themes introduced in Chapters 22–25, as well as elsewhere in this book, provide a backdrop to an overview of social justice as an increasingly central guiding principle for counselling and psychotherapy theory, training, and practice. The current chapter builds on these earlier chapters by highlighting the meaning and implications of a social justice perspective.

## Social justice as an overarching aim of therapy

There have been many historical examples of situations in which counsellors and psychotherapists have spoken out about social justice issues. Freud was instrumental in contributing to resistance against inhumane treatment of shell-shocked Austrian soldiers in the First World War (Brunner 2000). Many of Freud's early circle of psychoanalysts in Vienna, such as Wilhelm Reich, Alfred Adler, and Erik Erikson, did outreach work in deprived communities. Carl Rogers was a leading figure among psychologists in the USA who sought to improve the treatment of traumatised military personnel in the years following the Second World War, and tried to find ways to alleviate social conflict in Northern Ireland, South Africa, and elsewhere. Further information on ongoing debates around socio-political aspects of therapy can be found in Proctor et al. (2006), Totton (2006), and Wheeler (2006).

Over the past decade, the Counseling Psychology Division of the American Psychological Association, and the American Counseling Association have been in the vanguard of promoting social justice as a core value and goal of counselling and psychotherapy. These initiatives have encompassed the formulation of position statements and dialogues around the nature and meaning of social justice work (Aldarondo 2007; Kiselica and Robinson 2001; Lewis 2011; Ratts 2009; L. Smith et al. 2009), the development of appropriate training in this area (Goodman et al. 2004; Lewis et al. 2010; Weintraub and Goodman 2010), and research into the processes and outcomes of therapy that is informed by social justice principles (Erhard and Sinai 2012; Goodman et al. 2009; Singh et al. 2010b; Smith et al. 2012).

The key principles of social justice-oriented therapy to have emerged from the recent American literature can be divided into two broad areas. First, the therapist needs to develop a specific

position or stance in relation to their work with clients, characterised by a set of core competencies (Goodman et al. 2004): *ongoing self-examination* of the therapist's own knowledge, awareness, and attitudes around social inequality; *sharing power* with clients and working in a collaborative manner that builds on client strengths; *facilitating consciousness-raising* in clients, to allow personal issues to be viewed in their social, political, and historical context; and *leaving clients with the tools for social change*. A further key domain of social justice counselling and psychotherapy involves active *advocacy* on behalf of the needs and interests of client groups, or of individual clients within specific organisational contexts.

## Being and becoming a social justice-oriented therapist

At the present time, few training programmes address social justice in any depth, and post-qualifying learning around this topic is limited by the small number of articles published and training events/conferences held each year. Surveys of therapists in Britain who are interested in social justice suggest that this aspect of their work is implicit and aspirational rather than comprising a set of concrete skills and activities that can be clearly described (Singh et al. 2010b; Winter and Hanley 2015). As a result, practitioners have largely needed to carve out their own social justice identity and way of working.

The following sections offer an outline of some of the typical characteristics and learning processes associated with being and becoming a social justice-oriented therapist. To make use of a social justice approach in practice, it is necessary to have a clear idea of the similarities and differences between a social justice perspective and other models of therapy. This involves an appreciation of the practical meaning and implications of concepts of 'power' and 'justice', a model of practice, and a commitment to reflexive self-awareness around personal experience of social justice issues.

### The concept of power

A social justice approach requires an appreciation of how power operates in relationships and in society: who has control and who is in charge. It is no easy matter to understand the nature of interpersonal and social power. The concept of 'power' has many meanings and is employed in different ways by different people (Dowding 2011). Power differences are not merely a matter of individual attitudes and capabilities, but are embedded in social and institutional structures and practices. Power differences are not just 'in your head' – they are 'out there'. Psychological perspectives on power and oppression attempt to explain racism, sexism, and ageism in terms of factors such as attitudes, perceptions, and individual psychopathology. In the real lives of people who seek therapy, by contrast, the experience of racism, sexism, and ageism is a tangible component of everyday life. It happens. There is a physical side to interpersonal power. Being oppressed can involve violence, fear, and hunger, or the threat of these things. A person has the power to act in a certain way because they possess authority within a social system. Most interpersonal power in everyday life is of this type.

Within counselling and psychotherapy, by contrast, issues of power and control have been addressed by introducing the concept of *personal* power, for example the image of the therapist as being a 'powerful healer' or possessing a 'powerful presence'. The idea of personal power is described most clearly in some of the later writings of Carl Rogers. He regarded personal power as the reverse of authority power (Rogers 1978). This involves developing a particular set of values and style of relating: the aim is to produce people who trust in their own experience and have a profound distrust of all external authority. In other words, the sources of personal power come from within, rather than being drawn from external roles and statuses. Personal power depends on the capacity to be real, genuine, and empathic. Rogers (1978), and other therapists influenced by his ideas, regarded themselves as 'quiet revolutionaries', seeing their work as emancipatory and revolutionary. They



saw themselves as providing opportunities for clients to develop 'self-ownership', to make their own decisions, to claim their own personal authority and voice.

There is something missing in Rogers' ideas about personal power. At the time that he wrote *On Personal Power*, at the age of 75, Carl Rogers was probably the most famous living psychologist in the world. During his career he had received all the honours that the American academic system could bestow. His books had sold in their millions and he was revered whenever he made a public appearance. Although Rogers did, by all accounts, have a powerful personal presence and positive, facilitative impact on the lives of those who knew him, he was also a person who possessed a huge amount of authority power. The sources of this authority power were clearly identifiable in the social system. He was a leader of a major professional group. He could claim the status of a successful scientist. His reputation and prestige were promoted and marketed by the publishing industry. Yet these factors were not included in his understanding of his own powerfulness as a person. In many ways, Rogers was in an ideal position from which to reflect on these matters, but he could not recognise the social bases of much of his authority and influence.

Contemporary social justice therapists draw on both an understanding of power as a quality that can be fostered in individuals, in the sense of personal agency, assertiveness, constructive anger, and resistance to oppression, and a more conventional social science understanding of power as socially constructed and based in institutional and social structures. An essential dimension of social justice-oriented therapy is an acknowledgement of how power and control operate within the client–therapist interaction and ongoing relationship. It is also important to be informed about how political systems work.

Many social justice therapists have been influenced by the analysis of power by the Brazilian philosopher and educator Paulo Freire (1921–1997), who suggested that oppression operates by creating and maintaining a 'culture of silence' in which what is really happening is not talked about. To counteract this, people need to be supported to name their oppression and unmask the ideological tactics of ruling groups – a process that Freire (1970) called 'critical consciousness'. Individual and group therapy, along with other educational arenas, have the potential to provide a sufficiently secure environment in which this can take place.

## The concept of justice

For most people, 'justice' evokes images of criminal justice systems and law-making. Social justice-oriented therapy is based on a concept of justice as existing in all areas of social life. The key idea is that the moral ideas and values that inform any discussion of justice and equality are relevant to all situations in which people interact with each other, and with nature and animals. This broader concept of justice is reflected in the writings of Amartya Sen (2010) and Martha Nussbaum (2011), who have argued that it is important to promote and monitor justice at the level of basic human capabilities, such as having access to education and information, the freedom to engage in spiritual and religious activities, and the ability to pursue a family life. An example of one of the ways in which the concept of justice has been extended, in a form that is relevant to counselling and psychotherapy, is the practice of 'restorative justice', which involves the facilitation of dialogue and reparative action between the victim, perpetrator, and the community in which they live (Augusta-Scott 2017; Drewery 2004).

## Models of social justice therapy practice

It is useful to be able to draw on a model of social justice practice, even if local circumstances mean that creative and innovative strategies need to be devised that reach beyond that model. Many social action-oriented therapists use narrative theory (see Chapter 14) or feminist theory (see Chapter 25) as a meta-perspective from which they can tailor therapy interventions and styles of working in order to achieve social justice objectives. The Just Therapy Team in New Zealand, using

a family-oriented narrative therapy approach, is probably the longest-established therapy service in the world to operate from an explicit social justice perspective (Waldegrave et al. 2003).

In an important, but now rather neglected initiative, Holland (1990) developed a form of 'social action therapy', in the context of a community-based project based on three phases. First, it was necessary to help the client to move to a position of accepting their own personal self, that they were indeed a worthwhile individual, and that what had happened in their life had some meaning. This could be achieved by means of individual counselling or psychotherapy. A key aspect of this first phase was also to begin to let go of medical-model assumptions and pharmacological solutions. In the second phase, socio-political issues were explored in a group setting that allowed clients to disclose their shared, collective histories and make sense of their individual experiences within a social and cultural context. This stage was viewed as enabling participants to form supportive relationships and free up their energies and desires. Finally, participants had the possibility of working together to make demands on social institutions to gain access to resources that could make a difference to their lives in areas such as housing, childcare, and employment. A similar but more complex cyclical model was developed by Chung and Bemak (2012), incorporating activities such as mental health education, human rights information, and the integration of indigenous approaches to healing. A relationship-centred model of social justice advocacy has been developed by Goodman et al. (2013, 2018).

All models of social justice work emphasise a collaborative and flexible therapist style that seeks to work alongside the client in ways that promote personal strengths and the use of cultural resources. Distinctive features of social justice-oriented therapy include an openness to incorporate practical help, developing the ability to question existing structures of social control (critical consciousness), and solidarity with others.

## Self-awareness and training

As in any area of therapy practice, it is vital for a social action therapist to be able to develop a personal understanding of their own personal experience of injustice and environmental issues, and to be able to make connections between these experiences and their work as a therapist. Some social action therapists have a lifelong exposure to fighting for justice – for instance, through parents or grandparents who have been activists, or through growing up in communities that were in the front line of such struggles. The personal reflections of therapists in Chung and Bemak (2012) provide good examples of this kind of background. In other cases, training and professional experience can awaken a passion for social justice. In some training programmes, students may be required to undertake hands-on learning experience in deprived or threatened communities (Choi et al. 2015; Chung and Bemak 2012), read ethnographic accounts of life in such communities (Chung and Bemak 2013), carry out activist work in local communities or on the university campus (Lantz et al. 2016; Olle 2018), and study seminal documents such as the Universal Declaration of Human Rights and the Earth Charter.

Social justice therapists need to be aware of privilege and entitlement in their own lives, and the dynamics of these standpoints in everyday life. In training, one of the ways to accomplish this is to explore the relevance of privilege and power for faculty–student relationships (Chan et al. 2018). Another area in which it is necessary to develop self-awareness is around personal experience and values in relation to nature, consumption, and eco-issues in general (Laszloffy and Davis 2018).

A key element of therapist self-awareness is to develop critical consciousness of potentially oppressive aspects of routine, mainstream therapy approaches, such as in relation to the use of a 'language of deficit' (Gergen 1990), the ways that therapists may function overtly or implicitly as agents of social control, the ways that the organisation and location of therapy services may function to block or limit access to individuals from certain groups, and the possibility that participation in therapy may undermine traditional or indigenous community-based forms of healing and support.

Further information on social justice competencies, and their implications for training, can be found in Constantine et al. (2007) and Motulsky et al. (2014).

### Box 26.1: Therapy in a ‘surveillance society’

One of the defining characteristics of the contemporary social world, according to many sociologists and political scientists, is the extent to which we live in a ‘surveillance society’ (Lyon 2007). Sophisticated surveillance technology, such as CCTV and the use of biometric data, came to be widely used in the 1980s and their adoption was then further reinforced by the fear of terrorism evoked by 9/11 and similar events. At some level, all counsellors participate in surveillance through the duty to report to the relevant authorities when a client exhibits a risk of harming others. In some instances, the surveillance role of counsellors is much more explicit. Moore (2011) observed the operation of ‘drug treatment courts’ in Canada, in which drug offenders were mandated to receive counselling, in conjunction with regular attendance at court to monitor their compliance. Failure to attend counselling, or court, or violation of the treatment contract, could result in a prison sentence. The information presented to the court consisted not only of factual records of participation in therapy. Instead, ‘therapeutic surveillance is personal . . . it is built on relationships and intimate knowledge of those being watched’ (Moore 2011: 259). This kind of relationship between therapists and the criminal justice system raises many issues. At one level, it is intended to be benevolent, and may function in many instances in a caring and facilitative manner. On the other hand, it can obviously lead to situations where a client will choose to conceal information from their counsellor, and it places demands on the therapist in respect of maintaining a balance between working for the client and working for the court. The growing pervasiveness of surveillance systems in contemporary life means that therapists may need to become more aware of the sensitivities of clients whose lives have been affected by such practices, or who may fear the possibility of such damage occurring in the future.

## Social justice therapy in action

Throughout this book it is possible to find examples of therapeutic work informed by a social justice perspective, for instance in sections and chapters on gender diversity, nature-based therapies, and narrative and feminist therapy. The following paragraphs offer further examples that are explicitly based in the social justice literature.

*Inviting clients to talk about social and political aspects of their lives.* Social and political issues are likely to remain hidden in therapy if a therapist focuses their client’s attention solely on psychological themes. Politically informed therapists are curious about the social worlds of their clients, and the ways that clients can re-shape these worlds (Cushman 1995). Weiner (1998) describes how she set the scene for politically oriented conversations in the therapy room by installing a bulletin board in the waiting area, displaying leaflets, posters, and articles on political themes and examples of collective action, and ensuring that only recyclable beakers were available at the water fountain.

*Advocacy.* Social justice advocacy refers to actions taken to facilitate the removal of external barriers to opportunity and well-being of the client. This kind of work can involve empowerment and consciousness-raising with individual clients, who are then enabled to take relevant initiatives in their own lives. Alternatively, the therapist can function as an interface between the client and the wider community, either by brokering access to resources or speaking up on the client’s behalf. There is a strong emphasis on grounding advocacy in a collaborative empathic relationship with the client, the pursuit of mutually agreed goals, accompanied by therapist self-reflection, consultation with colleagues, and supervision (Ali and Sichel 2014; Goodman et al. 2018). Kozan and Blustein (2018) documented the experiences of counselling psychologists doing advocacy work:

- A client who had been hospitalised and treated in an oppressive way over many years was helped to understand the unfairness of the treatment he had received, resulting in him beginning to make demands for more appropriate care.
- A young African American woman who was depressed found it valuable to learn about research that made links between racial discrimination and depression.
- A client was accompanied to a court hearing and supported in giving her testimony.
- A challenge was mounted against an organisational policy that forbade speaking in Spanish (the favoured language of many employees and clients).

Other examples of advocacy work can be found in Chung and Bemak (2012) and other social justice sources. Although initially therapists may experience such activities as taking them beyond their 'comfort zone' (Goodman et al. 2018; Kozan and Blustein 2018), the therapists in these studies reported that advocacy initiatives are valued by clients and readily become integrated into an expanded therapeutic role.

*Conceptualising the client's social ecology.* An essential skill in social justice therapy is the capacity to make sense of the social world of a client, in terms of both sources of stress and oppression, and sources of support and opportunity. Williams et al. (2015) have developed a technique for visual mapping of the social life-world of a client based on an ecological model of human development.

*Working in a specific organisational setting.* Therapists who work in a specific organisational setting, such as a school, college, university, or hospital, have the choice of just being a clinician in an office or taking a more active part in shaping the culture or policies of the institution. For instance, Erhard and Sinai (2012) conducted a survey of school counsellors in Israel. The majority of the counsellors who completed the survey's questionnaire reported that around half of their allotted time was devoted to working with disadvantaged students, and that they perceived themselves as having a leadership and advocacy role in relation to promoting changes in their school – and in society at large – that would advance the academic and social status of these disadvantaged students. In another study, Lopez-Baez and Paylo (2009) conducted a detailed case analysis of a social justice counselling process that involved many aspects of a school system when resolving a case of bullying. This kind of work, in which a counsellor has a primary therapeutic relationship with an individual client, but is also a member of an institution and is able to mediate between the client and the wider institution, occurs not only in social justice therapy in schools but also in many other organisational settings.

*Working in collaboration with practitioners from other occupational groups.* A central characteristic of social justice therapy is that a therapist may be called on to work alongside colleagues from other occupational backgrounds. For example, outdoor therapy often involves collaboration between therapists and co-workers with qualifications and experience in outdoor pursuits and education. Counsellors in schools may need to talk to teachers and administrators. Any such involvement raises sensitive issues around client consent and confidentiality.

A detailed example of collaborative working is provided in Barrett and Olle (2016), which describes an initiative established by the police force in a city in the USA, designed to respond to the needs of young people with mental health issues who were picked up by the police. The key aims of this project were to ensure that these young people did not end up with police records, and that they received appropriate help as soon as possible. Barrett and Olle (2016) outline all aspects of the process of setting up this project, including selection of personnel, training of police officers, and negotiations around control of information. For some social justice therapists, an alternative approach to establishing collaborative relationships with colleagues is to build a professional network within a local community. For example, Burstow (2004), who has written about her activist role in relation to supporting survivors of psychiatric abuse, has demanded purposeful cultivation of working relationships with colleagues in different disciplines.

*Responding to structural inequality: poverty.* Therapy with individuals who are experiencing poverty is one area in which a social action approach is most fully developed. In a review of strategies for working with such clients, Overholser (2016) pointed out that ‘words are not enough’: therapists should not ignore the material needs of clients or the cultural and political factors that mean they are forced to live on inadequate benefits or wages.

One of the most thoroughly reported and researched social justice counselling initiatives is the Reaching Out About Depression (ROAD) programme, which has operated in a number of urban communities in some eastern states in the USA (Goodman et al. 2004, 2009; Weintraub and Goodman 2010). The aim of the project has been to support low-income women with self-identified symptoms of depression. The programme comprises two stages. First, the women participate in a series of workshops on topics related to depression and poverty. These workshops are run by women from within the community, and the participants are eligible to train as facilitators for subsequent workshops. Second, participants are paired up with counselling students who have received brief training in a feminist relational model of counselling (Goodman et al. 2004) and who act as ‘advocates’ for the depressed women who are seeking support. The advocacy partnership that ensues incorporates both practical (e.g. helping a partner to complain to a landlord) and emotional/psychological support (e.g. making sense of self-destructive patterns of behaviour). The advocate and partner meet for four to six hours each week over nine months, and the advocate receives regular supervision throughout this period. Interviews with women who had been helped by the project (Goodman et al. 2009) and counselling students who had served as advocates (Weintraub and Goodman 2010) indicated that offering a counselling relationship in the context of more practical forms of help was highly effective. At the same time, it was clear that the advocate–partner relationship could be challenging on both sides. The role of counsellor–advocate required being able to face up to challenging real-world conflict. Being a partner called for a willingness to ask for and receive help, which was hard for many women whose previous life experience led them to have low expectations that professional helpers would take them, and their needs, seriously.

*Responding to a cross-border issue: victims of human trafficking.* The complexity of responding to the needs of victims of human trafficking has been described by Pascual-Leone et al. (2017). In addition to psychotherapeutic help for trauma and loss, those who have been trafficked typically require assistance in such areas as finance, housing, health, dentistry, addiction, immigration status, and access to an interpreter. Counsellor or psychotherapist involvement in such work needs to go beyond mere one-to-one therapy.

In their analysis of how therapists might respond to the issue of human trafficking, Stotts and Ramey (2009) proposed that therapists need to take a more pro-active role: becoming sensitised to the nature of modern slavery and being open to the possibility that some clients may have been victims of trafficking, as well as appreciate the ways in which individuals may be affected by these activities. They also suggested that therapists should not only be willing to name this issue within the therapy room, but also use their position to enhance awareness of it within the communities that they serve. For instance, counsellors in schools could talk to young people about the risks of being lured into prostitution. There are many other cross-border issues that call for a social justice response that goes beyond symptom-oriented therapy, such as issues associated with war and militarisation, and working with refugees.

*Counselling people with disabilities.* The concept of ‘disability’ encompasses a wide spectrum of human experience. In literal terms, disability refers to a lack of capacity to carry out basic human actions and functions that are regarded by the majority of people as taken-for-granted, such as seeing, hearing, speaking, remembering, learning, walking, feeding, and holding. However, it is important, in any discussion of disability, to be clear that this concept can be understood and interpreted in radically different ways, each of which reflects a distinct political stance and mode of helping (Smart and Smart 2006).



The *biomedical* model of disability focuses attention on the biological causes of the disability, on medical and physical solutions, and implies that there is something abnormal or ‘wrong’ with the person. In addition, a person with a disability may be eligible for ‘sickness’ benefits under health insurance schemes. *Functional* models of disability emphasise the ways in which the person functions in the world, instead of focusing on the causes of the disability. Most counsellors working with disabled clients implicitly or explicitly adopt a functional perspective, and seek to explore issues associated with the client’s goals and how these can be attained. Unlike a biomedical perspective, which views disability in entirely negative terms, as a set of deficits, a functional approach introduces the possibility that there can be positive learning and growth arising from the person’s experience of their disability. Finally, a *social* perspective on disability adopts the position that, for the most part, it is not the disability itself that causes difficulties for a person, but the way that other people respond to the disability (Reeve 2006). For example, a person with a learning disability living in a traditional rural community in which people work on the land might not encounter any serious barriers to employment. The same person living in a society in which employment requires literacy skills might never find a job. The implication of a social perspective on disability is that effective helping on an individual basis is never sufficient – it needs to be supplemented by social action.

Principles of a social justice perspective on counselling and psychotherapy with people with disabilities have been developed by Olkin (1999), who has also published an inspiring account of her career as a disabled therapist fighting for the rights of disabled clients (Olkin 2010). A useful summary of Olkin’s guidelines for practice can be found in Artman and Daniels (2010).

*Social justice for long-term users of psychiatric services.* People who experience ‘severe and enduring’ mental health problems, such as chronic depression, schizophrenia, or bipolar disorder, encounter issues around an ability to work, sustain satisfactory relationships, or, in extreme cases, even to engage in basic self-care. Many counsellors and psychotherapists are reluctant to offer therapy to people within this category, because they view such clients as possessing complex and deep-rooted problems that require a more intensive form of intervention, such as inpatient treatment in a psychiatric unit or regular home visits from a support worker or mental health nurse. In contrast to this view, many users of mental health services regard counselling and psychotherapy as invaluable: Rogers and Pilgrim (2014) reported that mental health service users valued counselling above other treatments they had received, with 33 per cent of service users stating that they had wanted (but had been unable to get) counselling. In many cases, people living with long-term mental health problems seek therapy when some aspect of their experience (e.g. strong emotions, hearing voices, memories of abuse) is consistently *excluded from expression* in their social world (i.e. they are *silenced*). The purpose of therapy is to enable the person to negotiate social inclusion and re-engagement in a form that is meaningful to them (McLeod 1999) and to achieve a more coherent life-story (Lysaker et al. 2003; Roe and Davidson 2006). The aim is to contribute (along with other forms of help, such as medication, employment, supported housing, and self-help) to a process of *recovery* (Davidson et al. 2005, 2006; Gilbert et al. 2013; Lysaker and France 1999; Ridgway 2001). A crucial aspect of this area of work often involves the development of critical consciousness around the negative effects of institutional psychiatry (Whitaker and Cosgrove 2015).

*Ecologically informed therapy.* A broad array of outdoor therapies have been developed (see Chapter 17), some of which have been motivated by the idea that doing therapy in nature is a way of doing more effective therapy. However, an influential group of therapists regard outdoor work as a means of integrating ecological awareness into therapy, and using the experience of therapy as a way of making clients more aware of environmental issues and more willing to change their lifestyles in the direction of sustainable use of resources. An important figure in this movement has been the British psychotherapist and eco-psychologist Martin Jordan (1968–2017), whose research identified that a green political commitment was a motivating factor in the work of many therapists whose practice included outdoor sessions (Jordan 2014a, 2014b). In a parallel development, therapists who



operate on a conventional indoor basis have been working towards developing strategies for incorporating ecological and environmental issues and awareness into their work with clients (Blumer et al. 2012; Laszloffy 2009; Laszloffy and Davis 2018). Among the techniques for opening up eco-conversations identified by Laszloffy and Davis (2018) are: positioning plants and artwork that depicts nature in offices and waiting rooms; designing homework assignments that require clients to spend time in nature; curious inquiry into how the client's cultural background and religious/spiritual orientation have shaped their involvement with nature.

This list of social justice interventions is not comprehensive. There are many other examples that can be accessed in books and articles cited in the present chapter. The intention has been to illustrate the wide range of social justice work that is possible – from relatively limited change of emphasis within routine therapy, to ambitious funded programmes.

### **Box 26.2: The socio-political context of therapy: learning from extreme situations**

To understand the relationship between therapy and politics, it can be helpful to consider what happens in extreme circumstances. When a society is controlled by a totalitarian regime, it becomes very hard to do therapy. It is well known that many psychoanalysts were forced to flee from Nazi Germany because they were Jewish. What is less well known is that the psychotherapy that remained in Germany during the 1930s and 1940s was fundamentally compromised because clients and psychotherapists could not be honest with each other, for fear of being reported to the authorities for holding forbidden attitudes (Cocks 1997). Similar dilemmas have been reported by therapists working in the Soviet Union, Chile, and Argentina, at the times when these societies were under totalitarian rule (Totton 2000), in Norway during the Nazi occupation (Nilsen 2013), and by the Israeli psychotherapist Emanuel Berman (2006) in his reflections on the struggle to oppose the impact of aggressive militarisation on Israeli life. These analyses of the role of counselling and psychotherapy in times of war and imposition of totalitarian rule make it possible to identify the extent to which genuine therapeutic relationships and democratic egalitarian social life go hand in hand. It is notable that the main expansion of counselling and psychotherapy has occurred in North American and European societies with strong democratic traditions and values. The recent political turn in some countries, in the direction of authoritarian and anti-democratic rule, can be seen as representing significant threats to therapy.

## **Social action research**

Owing to their relatively recent emergence, social justice approaches to therapy have been able to draw on a wide range of available research methodologies, both qualitative and quantitative. A distinctive aspect of social justice research has been the use of research as an intervention – the process of collecting, analysing data, and disseminating findings is viewed as having the potential to raise critical consciousness of issues and empower research participants (Chapman and Schwartz 2012; Goodman et al. 2004; Johnson and Parry 2015). An example of this type of research, and the impact it can have on participants, can be found in the account of an action research project conducted with women in a low-income community (Smith and Romero 2010). As well as generating new ideas about therapy interventions that would be helpful, the women who took part in the project reported that it raised their awareness significantly, and empowered them to make positive changes in their lives.

## Conclusions

The reason that social justice has a chapter to itself is that it represents a fundamental shift in the history and evolution of therapy. While making use of psychological insights, social justice therapy opens up a new horizon for therapeutic work that re-sets the goal of therapy as going beyond the alleviation of symptoms and individual distress, to one of contributing to the task of building a more equal, humane, and convivial way of life. This shift is particularly timely and necessary at a time when people urgently need to collaborate with each other in order to avoid the destruction of the natural environment or any possible use of weapons of mass destruction.

There are two big ideas that come together in social justice therapy. The first idea is that the best way to deal with problems in living – emotional, psychological, behavioural, and relationship difficulties – is through collective action, by devising structures through which people can learn from and with each other, and support each other. The second key idea is that, to be effective, such structures need to be based in a moral stance that is characterised by equality between persons, mutual respect, and dialogue (Winter 2018). In a crucial analysis of recent developments in psychotherapy, Gorski and Goodman (2015) argued that, while multicultural therapy played a vital role in legitimising attention to the significance of culture in people's lives, it soon took the form of a 'colonialist' enterprise, in which the assumptions of those with social power and status (psychologists, psychiatrists, and psychotherapists) were applied in a downward direction and used to categorise and control those with less power (e.g. members of disadvantaged communities). Gorski and Goodman (2015) suggest that, by contrast, social justice therapy represents a *decolonising* viewpoint, that invites both clients and therapists to gaze *up* the power hierarchy, to shine a light on (and change) the social systems and structures that privilege the few at the expense of the many.



### Topics for reflection and discussion

- 1 What is your personal experience of privilege and entitlement, either in terms of your own status or through your interaction with others who claim privilege in relation to you? To what extent, and in what ways, has the existence of privilege and entitlement had an impact on the problems and difficulties you have had in your life?
- 2 Sociologically minded critics of counselling and psychotherapy have argued that therapy comprises an over-individualised response to personal problems and ignores the social origins and conditions that ultimately produce these problems (Furedi 2004; Pilgrim 1992; Smail 1991). Do you agree? Take any one field of counselling/psychotherapy with which you are familiar (e.g. student, marital, workplace, abuse survivors). To what extent does the practice of therapy pay sufficient attention to social justice? In what ways might the therapy that is offered be more (or less) effective if social justice was given more attention?
- 3 Reflect on the strengths and weaknesses of different theoretical orientations in counselling/psychotherapy (e.g. psychodynamic, CBT, person-centred) in relation to a social justice approach. Is there one theoretical perspective, or combination of perspectives, that you think is most (or least) applicable in this context?
- 4 Think about the counselling/psychotherapy agency where you work (or a counselling/psychotherapy agency you have used as a client). How do you feel when you are there? Do you have a sense of being powerful and in control, or do you have a sense of being in the hands of others? What are the physical cues (e.g. notices, leaflets, layout, furniture, décor) and behaviours that give you a feeling of being empowered, or a sense of being oppressed?

## Suggested further reading

A richly described, accessible account of the massive contribution of the narrative therapy community to social justice can be found in Denborough (2018). One of the key principles in social action therapy is that if a client is able to be powerful in the therapy room, they may be able to begin to be powerful in their everyday life. A short paper by J. B. Miller (2008) provides an invaluable starting point for making sense of how this can be accomplished. A current struggle for many therapists committed to a social action perspective is to find ways of facilitating critical consciousness and action around ecological issues. Laszloffy and Davis (2018) have compiled a comprehensive list of strategies for enabling this kind of learning to occur. *Toward a Socially Responsible Psychology*, edited by Elena Mustakova-Possardt and her colleagues (2014), brings together a series of works that establish the theoretical and research rationale for social action therapy. *Decolonizing 'Multicultural' Counseling Through Social Justice* (Goodman and Gorski 2015) takes off where the present chapter ends, and points the way towards the future development of social action approaches in therapy. The writings of Martin Milton (2018) and Laura Winter (2019) provide examples of how counsellors and psychotherapists can incorporate a social justice approach in their work with clients. *The Power Threat Meaning Framework* (Johnstone and Boyle 2018) is an emerging model of therapy practice that prioritises social justice concerns.



# PART

# 4

## Being a therapist

For a therapy client or service user, it is important to find a therapist who will be a good match in terms of values and personal style, and who will have the skills and knowledge necessary to help overcome one's current troubles and concerns. For practitioners, there is a constant drive to be the best therapist one can be, accompanied by painful feelings in situations that trigger a sense of not being adequate (or, more accurately, appropriate) – for whatever reason – to the needs of a particular client. For therapy service managers and policy-makers, the challenge is to build structures to ensure that good therapy is being delivered, and that unhelpful practices are identified and sorted out.

The chapters in this part of the book examine these questions from a variety of perspectives. Chapter 27 sets the scene by outlining what is known about the qualities and attributes of effective therapists. Chapter 28 looks at different ways in which being an effective therapist is not just a matter of good interpersonal skills, sensitive self-awareness, and relevant personal life experience, but also depends to a large extent on the operation of an array of support mechanisms and institutions: training, supervision, personal therapy, deliberate practice, appropriate career development opportunities, professional networks, and access to research knowledge.

Chapter 29 focuses on the importance of moral and ethical dimensions of therapeutic work. Ethical issues in therapy represent a crucial point of connection between personal aspects of being a therapist, in the form of awareness of personal values and the capacity to offer care and acceptance to people with different beliefs and backgrounds, and broader professional and societal aspects, such as adhering to codes of practice, being bound by legal statutes, and confronting injustice wherever it occurs. Chapter 30 looks at using research to inform practice and Chapter 31 highlights the different delivery formats to enhance access to, and the effectiveness of, therapy.

The final chapter draws attention to the requirement, particularly important at a time of social fragmentation and environmental destruction, of looking ahead and using therapeutic ideas and skills to make a contribution to building a better world.



# Chapter 27

## The qualities of effective therapists

<b>Introduction</b>	<b>409</b>
<b>Making sense of therapist competence</b>	<b>410</b>
<b>Dimensions of therapist competence</b>	<b>411</b>
Ethical sensitivity	412
Interpersonal skills	412
Personal 'soundness'	414
<i>An ability to draw constructively on life experience</i>	414
<i>The wounded healer</i>	416
<i>Professional self-doubt/absence of narcissism</i>	417
Conceptual ability	418
Mastery of technique	420
An ability to understand and work within social systems	421
Openness to learning and inquiry	421
<b>Learning from exceptional therapists</b>	<b>422</b>
<b>Conclusions</b>	<b>424</b>
<b>Topics for reflection and discussion</b>	<b>424</b>
<b>Suggested further reading</b>	<b>424</b>

### Introduction

Therapy is an activity carried out by a person. Therapy theories and interventions are not like software packages that can be downloaded and switched off and on. Therapy is delivered through a relationship with another person. The client experiences CBT, or psychodynamic psychotherapy, or any other type of therapy, through the way in which that therapy approach is expressed and enacted by their therapist.

A major debate currently within the counselling and psychotherapy professions concerns the personal qualities and attributes of competent therapists. A growing body of research evidence



reveals large differences between therapists in the outcomes they achieve with clients. An average therapist helps about 60 per cent of the clients with whom they work, around 10 per cent get worse, and the remainder are unchanged. However, some therapists help almost all of the clients they see, while others have little or no overall positive impact (Kraus et al. 2011; Okiishi et al. 2003). In the past, although it was understood that some therapists are more effective than others, there was no way to determine the seriousness or pervasiveness of this issue. In the last 20 years, however, it has become possible to compare the effectiveness of therapists in large data sets where clients completed a brief outcome measure at each session. These data clearly show that the chance of being helped by therapy depends more on who you see than the type of therapy you receive.

The aim of this chapter is to look at what it means to be a competent therapist – that is, what are the characteristics of effective practitioners? The chapter is organised around a model of seven dimensions of therapist competence. After a brief introduction to competence, there is a summary of the model, followed by more detailed discussion of each dimension in turn.

## Making sense of therapist competence

The concept of competence refers to domains of knowledge, skill, and experience that define what an effective practitioner – in any field of endeavour – is able to do. The notion of competence offers a broader perspective than looking at effective practice merely in terms of aspects such as skills and knowledge. Many competency frameworks have been developed within the field of counselling and psychotherapy, such as those around generic competencies shared by all therapists, specific competencies linked to the use of particular models of therapy such as CBT or family therapy, and competencies associated with areas of practice that require greater emphasis, such as multicultural therapy or working with young people.

Some researchers, practitioners, and trainers have argued that the concept of *expertise* provides a more appropriate perspective from which to think about the question of the skills and knowledge of effective therapists. ‘Competence’ focuses attention on what is necessary to be a ‘good enough’ practitioner, while ‘expertise’ invites consideration of the attributes of exceptional practitioners. One of the advantages of an ‘expertise’ perspective is that it makes it possible to make connections with an extensive literature on this topic: the issue of how to differentiate between ‘novice’, ‘competent’, and ‘expert’ practitioners has been explored in a wide range of occupational contexts. A particularly influential model of professional expertise was developed by the philosopher Hubert Dreyfus (1989). Within his framework, novice practitioners are viewed as exhibiting a tendency to stick to taught rules, and lack flexibility. The key difference that can be observed among more experienced, competent practitioners, is that they are able to use some kind of theoretical or conceptual scheme that provides them with a broader perspective on what they are doing and a capacity to take more information into account when deciding how to respond to situations. Finally, truly expert practitioners are able to draw on a tacit or intuitive understanding of situations, which allows them to generate creative or novel solutions. Expert practitioners also exhibit the belief and confidence that they can handle the most challenging situations, the ones that competent and novice practitioners have a tendency to avoid. A more detailed account of the Dreyfus model can be found in Flyvbjerg (2001), and the implications of the model for therapist training and development are discussed in Rønnestad and Skovholt (2013).

There has been considerable debate around how to define and measure therapist expertise (Hill et al. 2017; Tracey et al. 2014). For example, is expertise mainly a matter of achieving good results with clients, or is it better to explore it in terms of what a therapist does to get such results? By considering what the ‘best’ performers do, there is also a risk of losing sight of the fact that the concern of most clients is whether their therapist is good enough to help them rather than if they are a star performer. Furthermore, therapists can achieve exceptional results with a single or a few clients, even if their overall effectiveness is average to low.

Although there is ongoing debate around the meaning of expertise and the relative merits of a competence perspective versus an expertise perspective, there is broad agreement in the literature that it is necessary to adopt a developmental approach to these issues (Rønnestad and Skovholt 2013). It has been clear for some time that whatever makes a good therapist, it is not an innate characteristic they possess or a matter of intelligence or educational attainment (e.g. high marks in school or university exams). Nor is it a matter of completing a recognised professional training programme. Instead, the qualities that make someone able to be helpful and facilitative for another person whose life is falling apart, in the intense and pressurised environment of the therapy room, have their origins in childhood experience. In addition, these qualities are not static – they are constantly in a process of refinement, review, and revision. They are context-specific: therapists may be really effective with some clients or problems, yet struggle when faced with different clinical scenarios. Therapist competence is complex: therapeutic capability is made up of multiple threads of skill and knowledge that take their strength from the way in which they are woven together. A valuable way to think about therapist competence in developmental terms is to think about it as a ‘journey’. For example, the preparation that is undertaken early on in therapy can impact on the eventual journey in many different ways. No journey is ever smooth – there are always detours and barriers to be overcome before reaching one’s destination.

## Dimensions of therapist competence

A large body of work has been conducted into issues around defining and assessing therapist competence. Some of these initiatives have addressed questions around fitness to practise on completion of training, while more research-oriented studies have looked at the distinctive competencies associated with particular therapy approaches or work with particular client groups (Branson et al. 2015; Rodolfa et al. 2013; Roth 2015). The following seven dimensions of therapist competence reflect key themes from a range of such sources:

- 1 *Ethical sensitivity.* Personal beliefs and attitudes that reflect an acceptance of others, a belief in the potential for change, an appreciation of difference, and an awareness of ethical and moral choices. Sensitivity to values held by client and self.
- 2 *Interpersonal skills.* Competent therapists are able to demonstrate appropriate listening and communication skills, empathy, presence, an awareness of non-verbal communication, sensitivity to voice quality, responsiveness to expressions of emotion, turn-taking, structuring time, and use of language.
- 3 *Personal ‘soundness’.* Self-confidence, an absence of personal needs or irrational beliefs that are destructive to therapeutic relationships, a capacity to tolerate strong or uncomfortable feelings in relation to clients, secure personal boundaries. An absence of social prejudice, ethnocentrism, and authoritarianism.
- 4 *Conceptual ability.* The ability to understand and assess the client’s problems, to anticipate the future consequences of actions, to make sense of immediate process in terms of a wider conceptual/theoretical scheme, to remember information about the client, and to construct a case formulation. Cognitive flexibility, problem-solving skills.
- 5 *Mastery of technique.* Knowledge of when and how to carry out specific interventions, an ability to assess effectiveness of interventions, an understanding of the rationale behind techniques, the possession of a sufficiently wide repertoire of interventions or methods.
- 6 *An ability to understand and work within social systems.* An awareness of the family and work relationships of the client, the impact of the agency on the client, the capacity to use support networks and supervision. Sensitivity to the social worlds of clients who may be from a different gender, ethnic, sexual orientation, or age group.

- 7** *Openness to learning and inquiry.* A capacity to be curious about clients' backgrounds and problems. A capability to make use of feedback from clients, to be open to new knowledge, and to use research to inform practice.

Each of these dimensions depends on, and interacts with, all of the others. The first and last competencies in the list can be regarded as providing frames within which the other elements are embedded. Ethical sensitivity underpins and informs all aspects of the work of therapy, while openness to learning is the driver for lifelong learning.

## Ethical sensitivity

The extent to which ethical and moral sensitivity and awareness underpin all aspects of therapy practice is discussed in Chapter 29. Being a therapist involves operating from a position of accepting the intrinsic uniqueness and value of the person, and respecting the choices that the person has made as well as their broader capacity to choose. In practice, living up to these principles requires an awareness of the ways in which values and moral positions permeate therapeutic conversations, and an ability to work with the client to reflect on these positions when relevant to the task of addressing the problems for which they are seeking help. To be able to do this, a therapist also needs to be aware of their own values and moral assumptions, and to be able to place them in context in relation to wider cultural discourses and debates. Effective therapists engage in an active, ongoing process of inquiry and reflection around ethical and moral issues, to give them sufficient flexibility and perspective to be able to accommodate their own beliefs and values alongside those of their clients. The importance of this dimension of therapist competence is underscored by the finding – originally formulated by Carl Rogers and subsequently confirmed in many other studies – that clients view the capacity of their therapist to offer them unconditional acceptance, affirmation, caring, and validation to be fundamental – if these attitudes are not conveyed in an authentic manner, the therapy process will go nowhere.

To be able to have an honest and affirming connection with a client, a therapist also needs to be able to maintain a safe professional space, in which appropriate levels of confidentiality and competence can be guaranteed. This aspect of competence requires an understanding of good practice in relation to professional activities such as note-taking, storing information, supervision, and other matters. A further implication of competence around ethical sensitivity is an informed commitment to social justice as an underlying value of therapy, in whatever ways are relevant to the particular client and field of practice with which the therapist is engaged.

Within the counselling and psychotherapy literature, there is a growing acknowledgement that a deeper understanding of ethical and values issues in therapy is possible through study of the philosophy of humanism (Christopher 1996; Hansen 2006b, 2012; Hayes 2012; Stolorow 2012). Although humanism will be most familiar to therapists through its expression in humanistic psychology and psychotherapy, it is a philosophical tradition that has played a central role in the creation of modern world from the beginning of the nineteenth century. Basically, humanism promotes the position that human beings are agents who are responsible for the world they create.

## Interpersonal skills

Being a therapist involves skilfully managing one's interaction with another person (or group) for the specific purpose of helping them. To be able to do this requires the ability to make use of a wide range of interpersonal skills such as listening, questioning, self-disclosure, interpretation of meaning, and so on. Various writers have described this area of competency variously as counselling skills, communication skills, interpersonal skills, conversational skills, or helping skills. Further discussion of counselling skills can be found in Chapter 2.

There are some key areas in which interpersonal skills have a bearing on the effectiveness of therapy. Such skills enable a therapist to facilitate conversation that enables the client to describe

and explore their experience. The capacity to use interpersonal skills is particularly significant when the client expresses emotions such as anger. Skills are necessary to maintain a sufficient level of connectedness, attunement, and bonding, so the client has a sense of being accepted and 'met'. Finally, interpersonal skills are used to communicate the therapist's interpretation and understanding of the client's difficulties, and to explain how and why different activities and interventions will work. For some clients, those who simply want someone to listen to them, a minimal level of therapist interpersonal skill will do. However, other clients make high demands on the interpersonal skills of the therapist, including clients who are withdrawn, mistrustful, suspicious, hostile, confused or manipulative, or whose cultural background leads them to have different assumptions about how people talk to each other.

The role of interpersonal skills in therapy is highlighted in a series of studies by Tim Anderson and his colleagues (Anderson et al. 2009, 2016a, 2016b). In these studies, therapists' interpersonal skills were assessed by analysing their verbal responses to a set of video clips that portrayed difficult client scenarios. Their response to each on-screen client was rated in terms of a series of aspects of interpersonal skill: verbal fluency, emotional expression, persuasiveness, warmth, hopefulness, empathy, emotional connection, and responsiveness to interpersonal tension. In one study, Anderson and colleagues examined the characteristics of therapists who are highly effective, defined in terms of success rates assessed by change in symptom scores before and after therapy, and found that what was distinctive about the best therapists in their sample was that they possessed exceptional interpersonal skills that they were able to exhibit even when under pressure from clients (Anderson et al. 2009). In another study, the authors evaluated interpersonal skills in students right at the start of their training, and found that interpersonal skill as measured at that point predicted their effectiveness with clients in their first placement, one year later (Anderson et al. 2016a, 2016b). These results are consistent with findings of other research that found that poor outcomes in therapy are often associated with when a client puts pressure on a therapist (e.g. gets angry or seductive with the therapist) and the latter is unable to find a way to resolve the situation (Binder and Henry 2010; Dalenberg 2004). While most therapists possess interpersonal skills that are sufficient for dealing with run-of-the mill situations in therapy, the best therapists are sufficiently resilient and resourceful, in their way of being with clients, that they can cope when the going gets tough.

On the whole, therapists function best when they are able to help a client and are appreciated for their efforts. They are not comfortable when there is conflict or when anger is directed at them. People who can tolerate or enjoy conflict, or not being popular, are more likely to be found in the police force or senior management roles. Although interpersonal skills can be refined and developed during therapy training, they appear mostly to be established before training starts, in early childhood experience and in jobs that people had before entering training. As a consequence, training programmes typically make an effort to evaluate the interpersonal skills of applicants, and to reject those who have skill deficits. That therapy trainees, and qualified therapists, have already been pre-selected as having adequate skills, makes the research carried out by Tim Anderson and others – that differences in skills influence client outcomes – even more significant.

### Box 27.1: The importance of therapist emotional intelligence

Emotional intelligence refers to the ability to perceive and respond effectively to emotions in everyday life. A substantial amount of research has found that emotional intelligence is key to success in many occupations and is an aspect of general well-being. Kaplowitz et al. (2011) and Rieck and Callahan (2013) have found that therapists with higher emotional intelligence recorded better results with clients. One of the notable features of these studies was that emotional

intelligence was not assessed in terms of whether participants believed they demonstrated this quality, but through an actual test of their ability. In a subsequent research study, Pearson and Weinberg (2017) found that emotional intelligence improved over the course of therapy training. Although further work needs to be done to determine the generalisability of the findings, and pin down the precise ways in which emotional intelligence operates in therapy, it is likely that this concept functions as an umbrella term for several facets of therapist competence and can potentially contribute to our understanding of therapist development.

## Personal ‘soundness’

The dimension of personal ‘soundness’ relates to the capacity of a therapist to cope with the demands of the work, as well as to be able to function as a role model of how to handle stress, conflict, and emotional discomfort. The last thing a client needs is to find themselves with a therapist who uses the therapy relationship to fulfil their own needs (e.g. to be seen as powerful, wise, and important; sexual gratification; control; social friendship; financial greed) or to vent their crazy ideas and social prejudices. Less corrosive, but still unhelpful, is a therapist who deflects attention away from certain topics (e.g. sexuality, social oppression, particular emotions, the question of whether the therapy is making progress) because of their own discomfort around these issues.

The question of therapist ‘personal soundness’ has received a lot of interest in the counselling and psychotherapy literature, because most therapists recognise that it represents a crucial aspect of professional competence. It is a particularly sensitive issue because it is clear that there must be something unusual about anyone who would want to spend hours every week in a small room, alone with limited support from colleagues and a high degree of personal accountability, listening to other people talking about how unhappy they are and sharing vivid descriptions of hardship, adversity, abuse, and trauma. It takes a special kind of person to opt to do this kind of work, and the qualities that make up this ‘specialness’ have the potential to be powerful in destructive as well as life-enhancing ways.

It is not the case that effective therapists all have the same type of personality. There is a great deal of diversity among clients and it makes sense that such diversity will be matched in therapists. Also, it is not particularly helpful to generate long lists of positive therapist traits, because these are likely to describe effective people in any walk of life, rather than being distinctive to the field of therapy. In terms of impairment and fitness to practice, therapists are like anyone else in relation to the criteria around which addictions and severe mental health problems would result in suspension from work. There are two key characteristics of the personality of effective therapists: an ability to draw constructively on life experience, and professional self-doubt/absence of narcissism. The ‘wounded healer’ model provides a means of beginning to make sense of the underlying developmental processes that contribute to the emergence of these personal qualities. These topics are explored in the following sections.

### *An ability to draw constructively on life experience*

The task of listening and responding to a client while they talk about their problems inevitably triggers the therapist’s memories of personal life events that are similar in some respect to those being recounted by the client. This is a completely normal response. In everyday life, when someone talks about a problem, it is most usual for the receiver to give an example of when a similar thing happened to them. This kind of sharing of troubles brings people closer to one another. However, a therapist is not in the business of sharing troubles. In order to be able to use their personal memories and responses constructively, a therapist needs to be able to do at least three things. First, the therapist needs to use the memory or response to inform their empathic reaction to the client. Second, the therapist needs to be able to bracket-off or lay aside their response, in the service of not assuming



that their own experience was necessarily the same as that of their client – a good therapist accesses their own reactions while at the same time standing back from them. And third, the therapist needs to have an understanding of how that memory or feeling connects with other experiences in their life and with therapy theory. It is not helpful if a therapist is shocked or ‘thrown’ by their response to a client – or at least not so shocked or thrown that they lose their capacity to be present for the client.

Taken together, these core therapist skills can be summed up as an ability to draw constructively on life experience. It is taken for granted within the field of counselling and psychotherapy that entrants to the profession should already know how to do this. An important theme of both initial training and ongoing professional development involves continuing to evolve a more nuanced appreciation and understanding of personal life experience as a therapeutic resource.

The fact that this competency is something that can be refined in training, but not taught, has generated a large amount of research into the family life and childhood development of therapists (Barnett 2007; Burton 1970; Burton and Topham 1997; DiCaccavo 2002; Guy 1987; Henry 1966; Racusin et al. 1981; Spurling and Dryden 1989; Sussman 2007). It is essential to interpret the findings of these studies with caution. It is clear that each person follows their own unique developmental pathway within which some themes may be highly salient whereas others may be entirely absent. Also, most of this research was conducted with full-time psychotherapists in the USA. Research is lacking on the motivational patterns and developmental processes of non-professional or voluntary counsellors and psychotherapists, or on the experiences of therapists from non-white ethnic or working-class backgrounds.

The evidence that is currently available suggests that many therapists describe childhoods in which they had the experience of being cultural ‘outsiders’. This sense of being an outsider might be as a result of belonging to a cultural minority group (for example, the high proportion of Jewish therapists in the 1950s), living for some time in another country, or having parents who are exiles or immigrants. As Henry (1977: 49) puts it, in childhood many therapists ‘have been exposed to more than one set of cultural influences’. ‘Outsiderness’ can also arise from childhood experience of illness, loneliness (perhaps through being an only child or living in an isolated location), abuse, or bereavement. People who have grown up with a strong sense of belonging to a culture or social group readily develop an intuitive understanding of social rules and norms. By contrast, the experience of being a social ‘outsider’ motivates a child to learn about and understand relationships and interactions that are puzzling or threatening. This set of interests, and the ability to be a detached observer, are good preparation for being a therapist.

Another childhood theme that is frequently reported in interviews with therapists is conflict in family life, with the therapist as child taking the role of mediator or substitute parent. Consistent with this role, therapists often report that they were the dominant sibling in the family. Brightman (1984: 295) suggests that ‘the role of therapist itself may constitute a reenactment of an earlier situation in which a particularly sensitive and empathic child has been pressed into the service of understanding and caring for a parent (usually depressed mother) figure’. The child in this situation grows up with a need to care for others. As the sibling most involved in the family drama, from an early age they need to become a ‘junior psychologist’ who is adept at picking up behavioural cues of impending family conflict and skilled in finding ways to deflect or resolve difficult situations.

The pattern of childhood experience is unique for every therapist, but the more that it contains some of the elements described before, the more likely it is to lead to a motivation to enter therapy as a career. Marston (1984) and Farber et al. (2005) observe that there are multiple motives for becoming a therapist, such as contact, helping others, discovery, social status, power and influence, and self-therapy, and there are multiple pathways into this line of work. For some therapists, the routes into this area of work unfold over time. For example, individuals who have initially entered professions such as nursing, social work, and teaching may find themselves more and more attracted to and involved in the therapy components of their job. Undergoing therapy as a client may also function as a catalyst for the decision to become a therapist. The experience of meeting therapists or trainers who become influential role models can also be a factor.



It is important to acknowledge that the decision to become a therapist is not made lightly by someone. It constitutes a significant developmental process in its own right. Many talented therapists do not enter training until well into their middle years. There are also others for whom becoming a therapist is a pathway that they follow for a while and then realise that it does not suit them (Rønnestad and Skovholt 2013).

For therapists, the significance of what happened in their early childhood represents a strength and asset, yet also a potential source of vulnerability (Bernhardt et al. 2018). It is a strength because it provides a deep knowledge, understanding, and curiosity around aspects of life to which most people pay relatively little attention. Typically, therapists are people with a long personal history and curiosity around learning about how personal change is facilitated – by the time they become therapists, and throughout their career, therapists continue to read about and try out different ideas and interventions.

There are also several ways in which the themes discussed before can cause difficulties for therapists. Children who have been peacemakers or detached observers of the foibles of others may develop a grandiose sense of their own self-importance. Children who have had troubled lives may grow up to be troubled adults, and lack emotional soundness and resilience. Being a therapist may function as a way of avoiding dealing with painful personal issues: clients become a substitute for real-world relationships, and the therapist may unconsciously be trying to learn how to resolve personal issues by watching how their clients do it.

### *The wounded healer*

The ‘wounded healer’ model, initially developed by Jung, has been an influential framework for making sense of the key events in childhood (and in later life) that contribute to the development of therapists (Guggenbuhl-Craig 1971; Nouwen 1979; Rippere and Williams 1985; Zerubavel and Wright 2012). The wounded healer model proposes that the power of the healer (the priest or shaman in primitive societies, the counsellor or psychotherapist in modern society) derives from their inner experience of pain, loss, or suffering – their wound. This ‘wound’ gives the healer an excellent basis from which to understand and empathise with the wounds of clients: ‘making one’s own wounds a source of healing . . . does not call for a sharing of superficial personal pains but for a constant willingness to see one’s own pain and suffering as rising from the depth of the human condition which all men share’ (Nouwen 1979: 88). The wounded healer concept makes it possible to understand the ‘search for wholeness and integration’ (Spurling and Dryden 1989: 252), which characterises the lives of many counsellors and therapists, as a strategy for transforming the pain of negative life experiences into a resource for helping others.

A study that illustrates the significance of a wounded healer perspective is that carried out by Costin and Johnson (2002) into the backgrounds of counsellors and psychotherapists working in specialist eating disorder services in the USA. In a survey of service managers, Costin and Johnson found that, on average, more than half of therapy staff were known to be recovering from eating problems of one kind or another. These managers identified a number of ways in which these life patterns might make their staff vulnerable, including a risk of relapse or by being over-involved in the work and not taking care of themselves. However, on balance service managers regarded prior personal experience of an eating disorder as being an advantage for therapists, in that it made them more grounded and realistic, more empathic, and better able to instil hope.

Zerubavel and Wright (2012) offer a reappraisal and reconceptualisation of the wounded healer model in the light of current research. They suggest that the concept of the wounded healer can be clarified by introducing the notion of ‘trajectories’ of relapse and growth. They identify four possible trajectories. The ‘chronic dysfunction’ pattern describes instances in which a person is affected by a negative life experience and continues to struggle to cope with its impact. The ‘relapse’ trajectory occurs when a person oscillates between periods of recovery and effective functioning and periods of breakdown. The idea of a ‘recovery’ trajectory is used by Zerubavel and Wright (2012) to characterise the experience of people who overcome a difficult life experience and are able to return to a

stable level of functioning. Finally, the 'post-traumatic growth' pattern reflects the experiences of people who are able to make positive use of difficult life experiences.

Reframing the image of the wounded healer in terms of a set of dynamic and potentially alterable trajectories makes it possible to make sense of both the positive and negative aspects of difficult life experiences. Clearly, a wounded healer who is on a post-traumatic growth trajectory has the potential to be a really special therapist. On the other hand, a student or trainee who attempts to conceal a pattern of chronic dysfunction or relapse may become a poor therapist, particularly for clients whose problems overlap with or re-evolve the therapist's own issues. The model of Zerubavel and Wright (2012) does not make the assumption that a chronic dysfunction trajectory is immutable and fixed: with appropriate support, supervision, and therapy, a trainee or practitioner who demonstrates this pattern may be enabled to move to a different path.

There are some limitations to the wounded healer model. It draws attention to difficult experiences in early childhood, which downplays the significance of the extent to which therapists learn from personal experience at all stages of their life. It does not explain how therapists learn to channel their woundedness into useful skills. For example, research by Burton and Topham (1997) and Halewood and Tribe (2003) found higher levels of childhood abuse and trauma in therapists compared with people in other professions. However, it is difficult to determine whether therapists objectively had harder childhoods, or whether their training may have made them more aware of any hardship that was experienced. In addition, the wounded healer does not take account of the social stigma that may be associated with being a professional therapist who has previously been a patient or had problems. This is an issue that is particularly acute in certain areas of therapy practice, such as addictions work (White 2000a, 2000b).

In summary, although it is important to acknowledge the mythic origins and limitations of the wounded healer model, it has nevertheless been a useful myth for the therapy professions, because it has acted as a counterbalance to the 'myth of the untroubled therapist' (Adams 2013).

### *Professional self-doubt/absence of narcissism*

The ability to draw constructively on life experience and the notion of the wounded healer represent positive ways in which childhood experience provides an essential resource for therapist competence. However, an analysis of therapist competence also needs to consider the personal roots of non-competence. A recent programme of research examining the differences between therapists who were highly effective and those who had average outcomes found that the most effective therapists were more professionally self-effacing, and reported higher levels of professional self-doubt, than those who were less helpful to their clients (Nissen-Lie et al. 2010, 2017). This research also found that professional self-doubt and personal self-doubt operated as separate domains – the most effective therapists were secure and confident in themselves as people even while they questioned their effectiveness in the therapy room. There are two sides to this research. The finding that effective therapists engage in self-monitoring in order to balance different possible response to a client is consistent with the idea that they draw constructively on life experience, and their acceptance of themselves as people is consistent with having been able to resolve early wounds. The other side of the research is what it is saying about the therapists in these studies who were *less* effective. These were people who had inner doubts about their own value as people, while acting in relationships with others as though they were all-knowing (i.e. not doubting themselves as therapists). This pattern is known as narcissism.

The concept of *narcissism* comes from the Greek myth of Narcissus, a handsome youth who eventually perished because he fell in love with his own reflection. The precursors of narcissism are generally considered to be present in the way that babies and infants are generally adored and regarded as perfect in all that they do. For most people, this adoration is balanced by appropriate challenge and criticism. People who grow up to be narcissistic have never been helped to learn how to take criticism, or to put others first. Instead, they are repeatedly treated as special and better than others. What develops is a personality structure that combines an inner sense of worthlessness with an outer performance of perfection. While an element of narcissism or positive self-regard is a

necessary component of a healthy personality, as a counterbalance to harsh self-criticism, in people who develop narcissistic personality disorder this attribute becomes a central defining aspect of who they are. The patterns of childhood experience that are found in the early lives of many therapists create the potential for subsequent narcissistic personality structures. Being an outsider can cultivate a belief that one is better than those 'mere mortals'. Being a family peacekeeper at an early age can lead to a sense that one possesses special gifts and powers.

In some respects, therapist narcissism is institutionally reinforced within the counselling and psychotherapy professional literature and within popular culture, in the form of the therapist as a wise, nurturing, and heroic figure (Brightman 1984). Almost all therapy case studies portray the therapist (not the client) as the hero of the story, and textbooks tend to devote little attention to discussing or describing cases of failure. Nevertheless, the reality is that therapists are continually confronted by the limits of their understanding, empathy, and capacity to help. As a means of coping with an inner sense of inadequacy, some therapists evolve what Brightman (1984) has called a 'grandiose professional self' – an image of an all-powerful and all-loving therapist. The earliest observation of this phenomenon was made by Ernest Jones, the psychoanalyst who was a student and biographer of Freud. Jones (1951) wrote that some analysts kept themselves aloof and mysterious, acted as if they knew everything, and never admitted mistakes. He coined the term 'God complex' to describe such therapists. Marmor (1953) described this pattern as a 'feeling of superiority'.

The consequences of therapist narcissism have been explored by Glickauf-Hughes and Mehlman (1995) and Halewood and Tribe (2003). Narcissistic therapists do not readily accept feedback, and are deeply threatened by any manifestation of client anger towards them or criticism from colleagues. They may be driven by perfectionist tendencies and seek to impose their version of truth on others. Behind an apparently confident external image, the narcissistic therapist may hide a fear of being an imposter who is unable to be of any value to anyone. Ethical violations may arise from a sense that 'the rules don't apply to me'. These narcissistic and grandiose qualities are the opposite of the characteristics of effective therapists.

The significance of narcissism in relation to therapist competence is that it appears to be a specific risk factor within the therapy professions. As in any other walk of life, therapists who are disorganised, lazy, or anxious are likely to be less helpful to clients. Narcissism is in a different category because therapy attracts people who are narcissistic and such individuals may do well in training because they may be intelligent and verbally fluent, and confidently embrace ideas and interventions that they are willing to implement in practice. But, for clients, a narcissistic therapist is in many respects almost exactly the opposite of what they need.

### **Box 27.2: Links between therapist personal qualities and how the therapist is experienced by their clients**

Many research studies have explored the links between the personal qualities of therapists and the process of their work with clients. Hersoug et al. (2009) collected client ratings of the quality of their alliance with their therapist at regular intervals throughout the course of their therapy. Lower ratings (i.e. poorer therapy relationships) were reported by clients of therapists who had experienced relationship difficulties with their mothers during childhood, and had been assessed as having an interpersonal style, in everyday situations, that was cold, distanced, disconnected, or indifferent.

### **Conceptual ability**

Conceptual ability refers to the capacity to make sense of patterns of behaviour and experience in terms of relevant concepts and theories. There are many ways in which conceptualisation is practically useful in therapeutic work:

*Something to hang on to: structure in the face of chaos.* The experience of being a therapist is, typically, one of attempting to respond adequately and helpfully to complex and confusing sources of information. A client makes an appointment for a therapy session, apparently wishing to engage in a therapeutic process, and then sits slumped in his chair and says nothing. A highly successful professional woman enters therapy to deal with issues around work stress but soon talks about, and exhibits, the fear she feels about anything that reminds her of powerful memories of being a victim of violence. These are two examples of the sometimes dramatic contradictions that can be encountered in the therapy room. On some occasions, too, clients may move beyond any attempt to maintain a coherent and consistent social self. In exploring painful experiences, control can be lost. A client will report being stuck and hopeless, unable to see any way forward or to imagine any viable future, or become angry with their therapist. At these moments, or during later reflection on what has happened, it can be vital to be able to use a theoretical framework so as to begin to place what is happening into some kind of context. At difficult moments, theory gives a therapist a basis for reflecting on experience, and a language for sharing that experience with others (for example, colleagues, a supervisor), thereby enlisting support and guidance.

*Offering the client a way of making sense.* Traditionally, therapy approaches such as psychodynamic and person-centred have largely relied on experiential learning and on insights or new understandings that are framed in the client's own language and the dialogue between therapist and client. However, many therapists have found that it can be valuable for clients to acquire a theoretical framework within which they can make sense of their difficulties. Transactional analysis (TA) is one example of a therapy approach that has generated a wide range of client-friendly books and pamphlets, which explain TA concepts in straightforward non-technical language. Cognitive-behavioural therapists use psycho-educational interventions, and claim that the best evidence of whether a client has gained from therapy is when they can quote the theory back to the therapist and explain how they apply it in their everyday life. Even in therapies that do not overtly encourage clients to learn the theory, there is no doubt that many clients do, on their own initiative, carry out a certain amount of background reading and study.

*Constructing a case formulation.* One of the early tasks for a therapist, when beginning to work with a client, is to arrive at an overall 'formulation' of the case. A formulation usually comprises a set of hypotheses that make potential connections between the immediate problems being presented by the client, the underlying factors and processes that are responsible for these problems and through which they are maintained, the factors in the client's life that might facilitate or impede therapy, and the therapeutic interventions or strategies that might be used in working to resolve the client's problems. Some therapists construct written or diagrammatic formulations that are shared with their client. Other practitioners engage in formulation in a more implicit way, such as talking through the elements of a formulation with their supervisor. In either scenario, a useful formulation is one in which theoretical ideas are used to make links between observations – a case formulation that does not incorporate a theoretical or conceptual understanding ends up being no more than a list of presenting problems.

*Providing a framework for research.* Research can be regarded as a pooling of insight and understanding, by bringing together the observations and conclusions of a wide network or community of investigators. Research can also be seen as a way of building knowledge, by testing the validity of ideas and methods. It is very difficult to carry out productive research in the absence of theoretical frameworks. Although there may be some areas of knowledge-building in which it is sufficient merely to identify instances of phenomena, and itemise or classify them, the majority of scientific studies involve testing hypotheses derived from theory, or developing ways of theoretically conceptualising patterns of events. The points in the history of counselling and psychotherapy at which the most significant advances in understanding and practice were achieved, for example in the group of client-centred therapists led by Carl Rogers at the University of Chicago in the early 1950s, occurred when communities of inquirers managed to operate simultaneously across the domains

of theory, research, practice, and training (McLeod 2002). At these times, it was the generation of fertile theoretical ideas that made progress possible.

In counselling and psychotherapy, concepts and theories do not have the status of fixed ‘truths’, in the way that theories of relativity and gravity operate in physics. Instead, therapy concepts and theories function as ‘cognitive tools’ or ‘narrative templates’ that can be tried out for size in relation to whether they provide a handle on events and experiences in a client’s life or within the process of therapy (Hansen 2006b). In order to be able to use concepts in this way, they need to have been sufficiently ‘metabolised’ by the therapist, through being applied over a period of time to make sense of personal issues (Betan and Binder 2010). Taken together, these aspects of conceptual ability in therapy mean that, over the course of their career, effective therapists are able to develop a deep appreciation of the many nuances of meaning involved in key concepts that inform their practice, such as transference, empathy, or emotion.

## Mastery of technique

As discussed in Chapter 2, therapists draw on a wide range of skills and interventions. Important aspects of therapist competence include the ability to implement these techniques effectively, and the possession of a repertoire of techniques that is sufficient to allow the therapist to be responsive to what a client needs. Mastery of technique encompasses knowing when and how to carry out specific interventions, being able to monitor the effectiveness of interventions, understanding the rationale behind techniques, and being able to explain techniques to the client and if necessary instruct the client in their implementation. The training literature, and treatment manuals, offer guidelines about the use of techniques. Task analysis research has also generated evidence-based models of the application of interventions such as two-chair work.

If a therapy skill or intervention has the potential to be helpful for clients, it also has the potential to be unhelpful or harmful. For example, well-crafted empathic responses are able to facilitate deeper client exploration of difficult experiences, leading to new insight and understanding. However, poorly timed and inaccurate empathic responses may cut off the flow of client experiencing and undermine the client’s belief in the therapist. Similarly, although re-visiting painful memories may be transformative for clients who have experienced abuse and trauma, if done too early in therapy or without appropriate levels of support the same intervention can re-traumatise the client.

On the whole, analyses of what has happened in cases where clients have been harmed by therapy do not identify poor technique as a primary cause of such outcomes. Instead, harmful therapy appears to be associated with therapists who fail to take account of client feedback, are too confident in their own ideas about how therapy should proceed, or are morally exploitative. In many situations, poor therapist technique has a limited negative impact, either because the client and therapist can work together to find a different technique that works or because the client leaves therapy.

Assessing therapist competence around the use of techniques is not a simple feat. Implementing a therapy skill or intervention is not a matter of following a set of step-by-step procedures. Instead, a good therapist works collaboratively with clients, and is responsive to the client’s reactions and preferences throughout all aspects of the use of a technique. In addition, good therapists are innovative and creative, and may develop their own style of using a technique or combining techniques or be able to improvise in the moment. When reflecting on the use of a technique, either in training or supervision or as part of personal self-development, it is important to consider what happened before the technique was introduced (e.g. was that technique the only or best means of taking therapy forward at that point?) and then after the technique was completed (was it helpful for the client?). Also, within the sequence of activity that constituted the technique, how helpful or facilitative was each step? It may also be important to consider whether an apparent failure in the use of a technique may have been because the client was not ready at that time to make use of it, and that exploring what happened later in that session, or in subsequent sessions, may reveal that the client finds the intervention more useful at a later time.



## An ability to understand and work within social systems

Elsewhere in this book it is emphasised that therapy takes place in a social and cultural context. Therapist competence requires an awareness of how the process of therapy is shaped by these factors, and an ability to manage these influences. Some of the key social systems within which therapy takes place are:

- The specific organisational or institutional setting within which therapy takes place. What does this mean to the client and therapist, and how does it affect the way they are able to work together?
- The social world of the client, in respect of family, work, gender, ethnicity, sexual orientation, age, and other elements of cultural identity and lifestyle. Does the therapist have a sufficient understanding and appreciation of these social realities to engage effectively with the client? Does the therapist possess appropriate skills for exploring or finding out about these areas?
- The social identity of the therapist (e.g. social class, ethnicity). How is this perceived by the client, and handled by the therapist?
- The support network of the therapist – their colleagues, supervisor, personal therapist, and others. How actively and purposefully is the therapist able to use these resources to enhance their work with clients?

At the present time, there do not exist any measures of therapist social competence, or specific procedures for exploring this competency dimension. However, such questions regularly arise within clinical supervision. For example, a therapist may struggle to find a way of reconciling their personal ideas of how best to work with a client (e.g. how many sessions a client might need), while at the same time following the procedures or requirements laid down by their place of employment. Or a therapist may use supervision to work out how best to fill in the gaps in their knowledge of the cultural background of a client.

## Openness to learning and inquiry

One of the fundamental characteristics of effective therapists is that they are really interested in people, and are always seeking to expand their understanding of both individual clients and human existence as a whole. This area of competence is reflected in qualities such as curiosity, an openness to learning, and a critical or questioning attitude to received assumptions and generalisations. It is expressed in behaviours such as reading, attendance at seminars and workshops, deep and serious conversations with colleagues, participation in research, and self-practice (trying out new ideas and techniques on oneself). In the context of therapy practice, key markers of openness to learning and inquiry include active engagement in seeking and using feedback from clients, and professional self-doubt (continually reviewing the potential utility of other ideas and interventions that might be better suited to a client).

Openness to learning takes different forms at different stages of therapist development (Friedman and Kaslow 1986; Rønnestad and Skovholt 2013). At the early stage of therapist development, during primary training, the therapist absorbs ideas and techniques from the existing literature and is influenced by role models and mentors. At the next stage, professional consolidation, therapist learning is more self-directed, and begins to be more oriented towards identifying a personal style of doing therapy and pursuing personal interests such as developing expertise around the needs of specific client groups. Towards the end of a career, there emerges what has been described as therapist 'wisdom': a more abstract and holistic level of understanding. Although these areas of focus overlap – trainee therapists can be wise, and older therapists continue to benefit from reading the primary literature – they offer a useful framework for making sense of significant shifts over the course of a working life.

It is particularly valuable to consider the nature of therapist wisdom and what it means for this area of competency as a whole. Research into therapist wisdom has identified two main themes



(Levitt and Piazza-Bonin 2016, 2017; Răbu and McLeod 2018). First, wisdom arises as a result of a lifetime of struggling to reconcile fundamental dilemmas associated with the practice of therapy (e.g. the importance of theory versus the relationship; giving emotional energy and care to clients versus being available to one's own family). Second, wisdom represents a critical or questioning response to current debates and assumptions – the insights of wise therapists function as a means of continually renewing theory and practice. These facets of wisdom function as a reminder that the knowledge base of therapy is not static, but always undergoing revision – at both collective and individual levels.

## Learning from exceptional therapists

Over the past decade, a series of research studies have examined the characteristics of senior and 'master therapists' – practitioners nominated by their peers as the 'best of the best', the therapists that they would recommend to a family member. The value of these studies lies in their capacity to use the broader perspective available to highly successful practitioners, who have survived the hazards of practice and thrived, as a means of highlighting the attitudes and strategies that are associated with excellence in the field of counselling and psychotherapy.

Jennings and Skovholt (1999) interviewed ten master therapists (seven women and three men) aged 50–72 years from a wide range of theoretical orientations. All of these therapists worked full time in private practice. The conclusions that emerged from this study were that master therapists are:

- voracious learners;
- sensitive to, and value, cognitive complexity and the ambiguity of the human condition;
- emotionally receptive, self-aware, reflective, non-defensive, and open to feedback;
- mentally healthy and mature individuals who attend to their own emotional well-being;
- aware of how their emotional health affects the quality of their work;
- in possession of strong relationship skills;
- convinced that the foundation for therapeutic change is a strong working alliance;
- experts at using their exceptional relationship skills in therapy;
- able to use their accumulated life and professional experiences as a major resource in their work.

In a further study, Rønnestad and Skovholt (2001) interviewed 12 senior therapists with a mean age of 74 years, and 38 years of post-qualification experience. Four major themes emerged from the data, each of which represented a key aspect of ongoing learning and development for these therapists:

- 1 The impact of early life experience.
- 2 The cumulative influence of professional experience.
- 3 The influence of professional elders.
- 4 Personal experiences in adult life.

These studies show that there are a number of characteristics that appear to be common among highly effective therapists. For example, they are practitioners who are not bound to one approach or set of assumptions. Even if they nominally demonstrate allegiance to a particular therapy approach, they read widely and are open to new learning and new sources of influence. Master therapists are interested in other people and are comfortable in relating to others in an open and non-defensive manner. In addition, master therapists take care of themselves emotionally, and devote energy and attention to making sense of their personal life experience. Further research into the qualities of

master therapists has confirmed the themes identified in these early studies (Jennings and Skovholt 2016; B. Miller 2007; Skovholt and Jennings 2016).

Goldfried et al. (1998) confirmed many of these findings. They invited master therapists (CBT and psychodynamic), nominated by their peers, to provide a tape of a good session with an ongoing client and to indicate the part of the session that was particularly significant. The tapes were analysed using a coding system for therapist interventions that looked at skills such as support, focus on emotions, self-disclosure, and much else (over 40 different factors). Comparisons were made between (1) CBT and psychodynamic therapists, (2) 'special' versus 'routine' parts of the sessions, and (3) the performance of these master therapists versus that of 'ordinary' therapists in a previous controlled study. The authors found that there were relatively few differences between the CBT and psychodynamic master therapists, and that the master therapists were more similar to each other than were the 'ordinary' therapists. Finally, the results showed that both CBT and psychodynamic master therapists were most alike during the significant parts of the sessions analysed, and were more different in the 'routine' parts of the sessions. These findings provide some evidence for the convergence of styles in master therapists from quite distinct theoretical orientations, and support the conclusions of Jennings and Skovholt (1999) that expertise in therapy is largely a matter of generic interpersonal skills and personal qualities, rather than the application of specific techniques.

Research on passionate and effective therapists provides richly described images of what to aspire to, for both therapists in training and more experienced practitioners. This body of research is the therapy equivalent of a 'master class' – an opportunity to get a glimpse of what is possible. In other fields, such as music, it is taken for granted that some performers are exceptional and considered a source of learning and inspiration. The intention is not that everyone who attends a master class with a famous musician will attain that level of expertise. The aim, instead, is that they might be enabled to move a little bit in that direction. The situation is less clear-cut in the world of counselling and psychotherapy, because until recently it was not possible to determine with any confidence who was actually a 'master therapist' and who was not. The availability of research that is now beginning to identify exceptional performance in therapy with some degree of reliability has begun to open up new sources for therapist learning and development.



### Case study 27.1: A case study of an exceptional therapist

A unique study involved detailed analysis of the work of a therapist who achieved exceptional results with clients (Hansen et al. 2015). The therapist, Eri Vlass, was employed in a therapy service in Australia in which outcomes for all clients, seen by a substantial number of different therapists, were collected on a routine basis. She described herself as using a time-limited integrative approach that incorporated a range of elements: CBT, compassionate mind training, sleep hygiene, nutrition, psycho-education, meditation, and hypnosis. In interviews, her clients described her as a welcoming, beautiful, and charismatic person 'with the ability to make a strong, immediate connection' and capacity to offer the client a new perspective on their life. What can be learned from this study? This highly effective therapist used a unique and idiosyncratic approach to therapy that she had evolved herself, and that was a good match for the way she was as a person. As a result, her response to clients was authentic, resourceful, coherent, and consistent, and provided clients with an experience of meeting a 'special' person. It is clearly important to carry out other in-depth analyses of exceptional therapists to determine the extent to which the findings of Hansen et al. (2015) represent a general pattern. Nevertheless, the case of Eri Vlass suggests that therapist expertise is not merely a matter of exceptional personal soundness or technical mastery, but a combination of the two: stand-out therapists are those who create a blend of ideas and methods that allows them to express and fulfil who they are and what they stand for.

## Conclusions

The task of maintaining competence and effectiveness is a core ethical responsibility for any therapist. It also represents a collective responsibility for the profession as a whole, including trainers, supervisors, researchers, and leaders of professional bodies. The message of the present chapter is that therapist competence comprises a set of interlocking skills and qualities, each of which is important itself. While actual effectiveness with clients, and client retention, comprise the ultimate bottom-line criteria for assessing competence, there are many situations in which it is hard to assemble reliable data to determine whether a particular therapist is more, or less, effective than their peers. In addition, a therapist may be highly competent and effective with one client, while failing to help another client. It is therefore essential to recognise that therapist competence is multi-faceted and context-dependent. The implication, therefore, is that it is necessary to adopt a stance of professional self-doubt in which the effects of interventions are continually reviewed, and client feedback is taken seriously. The tendency, within much of the therapy literature, to attribute success to the efforts of the therapist and failure to the inadequacies of the client is not consistent with such a stance.



### Topics for reflection and discussion

- 1 To what extent, and in what ways, have your early life experiences predisposed you to have an interest in becoming a therapist? For example, have these childhood and adolescent events and experiences influenced your choice of theoretical orientation, or your commitment to work with particular client groups?
- 2 Does the metaphor of the therapist's 'journey' apply to your life? Where are you now in terms of that journey? What might be involved in the next stage of the journey? What other images or metaphors might also be relevant in conveying your sense of your development as a therapist?
- 3 How valid is Sussman's (2007: 25) view that 'behind the wish to practice psychotherapy lies the need to cure one's inner wounds and unresolved conflicts'? What are the implications of this statement for therapist training?
- 4 How would you know whether someone is a competent therapist?
- 5 As a client, have you been aware of any competence issues in your therapist(s)? For example, was your therapist more competent in some areas than others? What difference did therapist competence make to what you eventually gained from therapy?

## Suggested further reading

An invaluable source of further information and deep insight on the issues addressed in this chapter is *The Developing Practitioner: Growth and Stagnation of Therapists and Counselors* by Helge Rønnestad and Thomas Skovholt (2013). Bohart (2015), Weingarten (2010), and Marzillier (2010) have published powerful and moving autobiographical accounts of links between their personal lives and their work as therapists. A series of books by Jeffrey Kottler and Jon Carlson explore the stresses and satisfactions of being a therapist (Kottler 2003; Kottler and Carlson 2003a, 2003b, 2006, 2008, 2009). The concept of the 'master therapist' has generated a publishing mini-boom. Especially recommended are: *On Being a Master Therapist: Practicing What You Preach* (Kottler and Carlson 2014), *How Master Therapists Work: Effecting Change from the First Through the Last Session and Beyond* (Sperry and Carlson 2013), and *Expertise in Counseling and Psychotherapy: Master Therapist Studies from Around the World* (Jennings and Skovholt 2016).

# Chapter 28

## Professional structures for supporting therapist competence

<b>Introduction</b>	<b>426</b>
<b>Training</b>	<b>426</b>
Primary training	427
<i>Acquiring a theoretical framework</i>	428
<i>Counselling and interpersonal skills</i>	428
<i>Personal development</i>	429
<i>Professional issues</i>	430
<i>Supervised practice</i>	430
<i>Using research to inform practice</i>	430
<i>Preparation for lifelong learning</i>	430
Post-qualifying training/CPD	430
<b>Supervision</b>	<b>431</b>
<b>Enhancing therapist self-awareness</b>	<b>435</b>
<b>Personal therapy</b>	<b>435</b>
<b>Meditation</b>	<b>437</b>
<b>Journaling</b>	<b>437</b>
<b>Self-practice</b>	<b>438</b>
<b>Deliberate practice</b>	<b>439</b>
<b>Therapist well-being</b>	<b>440</b>
<b>Career development</b>	<b>442</b>
<b>Institutions</b>	<b>442</b>
<b>Research</b>	<b>442</b>

<b>Conclusions</b>	<b>443</b>
<b>Topics for reflection and discussion</b>	<b>443</b>
<b>Suggested further reading</b>	<b>444</b>

## Introduction

Therapists do not work in a vacuum. Being a therapist involves being part of a network or system of education, training, research, and service delivery that exists at a societal level in order to develop and maintain the quality of counselling and psychotherapy provision. The key elements of this system include training, supervision, personal therapy and other therapist development activities, well-being programmes, and a range of institutions. This chapter offers an introduction to how each of these different aspects of the social organisation of therapy operates, and how they contribute to the overall therapy landscape. When considering this aspect of therapy practice, it is important to recognise that professional structures to support the delivery of competent therapy have not resulted from rational planning and are not, to any appreciable extent, evidence-based in the sense of being informed by research findings. In most countries, government regulation of therapy sits alongside a wide range of commercial and voluntary sector/non-governmental organisation/third sector initiatives. Unlike other fields such as healthcare and education, there have been few attempts to make sense of therapy provision and therapist development as a whole, or to establish joined-up policies. As a result, this area is fragmented and includes many examples of potentially valuable innovative practice that have not been disseminated across the system as a whole.

## Training

Therapist training is the cornerstone for the provision of effective therapy, because it represents the one area in which it is possible to define what is required in order to offer good therapy, and ensure that qualified practitioners have been sufficiently prepared to deliver it. Training also prepares students to be able to appreciate and take advantage of support structures that they can draw on over the course of a career, such as supervision, research, continuing professional development (CPD), membership of professional bodies, and well-being activities.

Before moving on to discuss the ways in which therapy training programmes are structured, it is necessary to highlight that there is limited evidence that therapy training contributes to greater therapeutic effectiveness, as defined by client outcomes. There are two key sources of evidence around this question: (1) research into the effectiveness of lay, untrained, or 'paraprofessional' therapists, and (2) longitudinal studies that have tracked the outcome statistics for therapists over the course of training. A number of studies have compared the effectiveness of paraprofessional counsellors with that of fully trained professional therapists, or looked at the outcomes achieved by professional therapists at different points in their training. Overall, these studies reveal only minimal differences in effectiveness associated with training status. Reviews and discussion of this body of research can be found in Beutler et al. (2004), Lambert and Ogles (2004), and Rønnestad and Ladany (2006). The only consistent result that favoured trained therapists was that they had fewer clients who dropped out of therapy.

In some large counsellor training programmes in the USA, trainees may work in a university-based counselling service for several years, thus making it possible to track their client success rate year by year. Studies carried out in such clinics have found that trainee effectiveness does not improve as a result of training (Erekson et al. 2017; Hill et al. 2015; Owen et al. 2016b). Although

Hill et al. (2015) were able to identify important changes in trainee awareness, skills, and knowledge, these gains were not matched by improvements in the outcomes reported by clients. Owen et al. (2016b) found marked differences between trainees: although the majority did not display any change in effectiveness over the period of their training, some showed substantial improvement while the effectiveness of others deteriorated. It is important to be aware that these studies carefully considered their findings from all angles, including the possibility that more advanced trainees might be working with more complex cases. The studies were carried out in leading training institutions, by highly skilled trainer-researchers who had no incentive to uncover negative effects.

These findings can be understood in several different ways. The most likely explanation is that all effective therapy depends on the provision of a set of common factors (such as a warm relationship and the instillation of hope), which depend on basic human qualities that are relatively unaffected by training. On the other hand, there are many commentators from within the professional community who question the validity of these studies and argue that over a mixed caseload of difficult clients, a properly trained therapist will always do better than a minimally trained volunteer. However, a definitive study that confirms this position has yet to be published. The key point here is that it is by no means obvious that the training practices that are currently being followed are necessarily optimal: there is a great deal to be learned about how therapy trainees can be helped to achieve their maximum potential.

## Primary training

Primary, initial, or basic training takes the form of a training programme that leads to a licence to practise as a counsellor or psychotherapist. The length, structure, academic level (non-graduate, undergraduate, or postgraduate) and disciplinary basis (i.e. whether it is considered a branch of psychology) of basic training differs widely across countries. However, the minimum requirement would be the equivalent of two years of full-time study, with many programmes lasting much longer.

To understand the structure of current primary training programmes in counselling and psychotherapy, it is necessary to know about the history of training in this field. The earliest area of therapy to develop a formal training schedule was psychoanalysis. The basic training medium for psychoanalysts has been the training analysis. Trainees in psychoanalytic institutes enter analysis with a senior member of the institute. Throughout their period of training they may undergo training analyses with two or more analysts in this way. A training analysis was considered to be the only way in which an analyst could learn about what psychoanalysis was really like, although theoretical seminars, case discussions, and child observation studies came eventually to be added to the psychoanalytic training programmes in many institutes. The assessment of suitability of candidates for qualification as analysts was largely determined by the training analyst. The privacy and secrecy surrounding these arrangements precluded public discussion of training issues; the suitability of a candidate was based solely on professional judgement, with no appeal possible. The potential oppressiveness of this kind of training has been discussed by Masson (1988) and others.

The emergence of client-centred therapy in the 1940s and 1950s brought with it a whole set of new ideas about how to train therapists. Rogers and his colleagues introduced students as co-therapists in sessions with clients. Students practised counselling skills on each other. The 'T-group' or personal growth group was applied to counsellor training, with trainees participating in small experiential groups. Students watched films of sessions and analysed recordings and transcripts. This phase of development in approaches to therapy training featured a more open and multifaceted approach to learning technique and the introduction of other means of facilitating self-awareness (for example, encounter groups), rather than a reliance solely on personal therapy. There was also a degree of democratisation in the training process, with student self-evaluation being considered alongside staff appraisals.

During the 1960s and 1970s, the main innovation in therapy training consisted of the introduction of structured approaches to skills training. These approaches were used not only on counsellor and



psychotherapist training courses but also in the context of shorter skills courses designed for people in other helping or human service professions, such as teaching, nursing, and management. The first of these structured approaches was the human resource development model devised by Carkhuff (1969a, 1969b). Other packages of a similar nature were the micro-skills model (Ivey and Galvin 1984), the skilled helper model (Egan 1984), and interpersonal process recall (Kagan et al. 1963). Although these models and approaches differed in certain respects, they all contained carefully structured training materials in the form of handouts, exercises, and video or film demonstrations, which would take trainees through a standard programme for learning specific counselling skills. A widely used contemporary example of this approach can be found in Hill (2014), Hill and Lent (2006), and McLeod and McLeod (2011).

More recently, most therapy training has tended to devote increased attention to the role of clinical supervision. There have also been a number of specific areas of innovation. Video is widely used to facilitate feedback on trainee performance both in the context of role-play and sessions with real clients (Manring et al. 2011). Feinstein et al. (2015) have developed an apprenticeship model of training that involves students sitting in on therapy sessions run by experienced clinicians, and gradually taking on more responsibility for the case. A further significant area of innovation is centred on the systematic implementation of learning principles using self-practice and deliberate practice (discussed in later sections of this chapter).

There is broad consensus regarding the elements that need to be included in training courses (McQuaid 2014). Although different courses may emphasise some of these activities at the expense of others, all programmes include substantial coverage of theory, skills, personal development, professional issues, supervised practice, and research awareness. Running through all of these elements is the quality of the relationship between trainer and trainee. Research studies have consistently found that participants in therapy training identify their relationship with a mentor or role model as a key factor in supporting their learning and development (Rønnestad and Skovholt 2013).

### *Acquiring a theoretical framework*

The theory component of courses may include models of therapy, basic psychological theories in areas such as developmental psychology, interpersonal behaviour, and group dynamics, an introduction to psychiatric terminology, areas of sociology relating to social class, race, and gender, and neurobiology. There is general recognition that students should not merely know about theory, but should be able to apply it in practice. A key issue in this area of training is whether to introduce students to one theoretical orientation in depth, or to expose them to several theoretical models. Training based on single-model therapy approaches enables students to explore a coherent body of theory in depth, but at the expense of lack of knowledge of alternative perspectives. Sequential teaching – a block on one approach followed by a block on another approach – is adopted in many programmes, but may be confusing for students unless they are also offered opportunities to reflect on theoretical differences. Some training programmes that are grounded in an integrative theoretical perspective provide students with a specific theoretical synthesis (see, for example, Yager and Feinstein 2017).

### *Counselling and interpersonal skills*

The concept of *skill* refers to a sequence of therapist actions or behaviours carried out in response to client actions or behaviours. Many therapy training programmes have adopted or adapted some version of the micro-skills training approach originally developed by Ivey and Galvin (1984), which breaks down the task of counselling/psychotherapy into a number of discrete skills such as attending, open and closed questions, encouraging, paraphrasing, confrontation, etc. Trainees are given written descriptions of positive and negative examples of each skill, watch a video of an expert demonstrating the skill, then engage in videotaped practice of the skills with other trainees acting as

clients. After receiving feedback, the trainee attempts the skill once more. This sequence is repeated until the trainee reaches an appropriate level of competence in the skill.

### *Personal development*

The importance of therapist self-knowledge and self-awareness is accepted by all of the established approaches to therapy. Traditionally, courses in psychodynamic therapy require trainees to undergo personal therapy throughout their period of training. The number of sessions stipulated varies widely, from ten sessions to twice weekly over several years. An alternative approach to personal development adopted by many courses is experiential work in groups. These groups may be run by external consultants or leaders, course tutors, or even on a self-help or leaderless basis. The aims of such groupwork are similar to those of personal therapy, with the added dimension that the quality of relationships and support developed in the groups will benefit the learning that takes place in other areas of the course as a whole. Work in small groups can also enable therapists to identify and clarify the values that inform their approach to clients. Personal learning diaries and journals are used on some courses to facilitate personal learning and to record the application of learning in practice. The diary or journal is particularly helpful in assisting the transfer of learning and insight beyond the course itself into the rest of the personal and professional life of the trainee. The quality and depth of personal exploration and learning on counsellor training courses can often be facilitated through the creation of suitable physical surroundings. Training groups may use residentials, which are often held in countryside settings away from the usual training premises, to construct a 'cultural island' where relationships are strengthened and new patterns of behaviour tried out. The personal meaning of therapy training for many trainees is that it is a time of intense self-exploration and change, which has implications for partners, family members, and work roles.



### **Case study 28.1: The personal impact of therapy training**

Therapy training can be highly stressful. Folkes-Skinner et al. (2010) published a detailed case study of the experience of Margaret, a student on a leading university-based counsellor training programme in the UK. In many respects, Margaret was well prepared for seeing her first client. She was 50 years of age and able to draw on a wealth of life experience that included a successful professional background in a business environment. She was well able to handle interactions and form relationships with people from all walks of life. Margaret was in a stable and supportive relationship, and had personal experience of being a therapy client. She had worked on a telephone helpline, and had completed a two-year pre-clinical part-time training qualification. However, despite these qualities and attributes, when interviewed soon after starting to see clients, she reported that the work was painful and upsetting, and that it triggered feelings of guilt around her own capacity to deal with such situations. Although Margaret was able to work through this crisis, by drawing on her own personal resources and the support of tutors and fellow trainees, her experience illustrates the level of emotional intensity and personal challenge that is associated with counsellor training, even when the student is well suited to a counselling role and has adequate support.

Kareem (2000) and White (1997) have argued that there are dangers for trainees in losing their own personal values and ways of knowing as they become socialised into a professional, psychological, and individualised way of seeing the world. As a result, there can be significant repercussions on the trainee's relationship with their partner, friends, and family members (Harding-Davies et al. 2004; Pack 2010; Rath 2008; Truett 2001).

### *Professional issues*

Training courses include careful consideration of a wide range of professional issues. Principles of ethical practice are given prominence on courses, as in discussion of cases. Other professional issues that are covered include: power and discrimination in therapy, particularly with respect to race, gender, disability, and sexual orientation; adopting a social justice orientation; case management and referral; boundary issues; professional accountability and insurance; inter-professional working; the organisation and administration of therapy agencies; and membership of professional bodies.

### *Supervised practice*

At some point in training students will begin work with real clients, rather than practising with course colleagues. Supervision of trainees can be conducted in regular one-to-one meetings with a supervisor or through group supervision. A broader discussion of the nature of supervision is introduced later in this chapter.

### *Using research to inform practice*

Understanding the ways in which evidence from research can be used to inform practice is an element of all training programmes. This takes the form of such activities and topics as: workshops on research awareness; the ability to read research papers and draw appropriate conclusions from them; training in research methods; designing and implementing a piece of research; using research-based knowledge in the context of client work; and critical appreciation of the strengths and limitations of different research methodologies.

### *Preparation for lifelong learning*

It is clear that therapist learning and development occurs across the whole of a career, and that knowledge and skills acquired during basic training represent merely a first step on a long journey. In addition, there is never enough time in basic training to cover all topics at the level and depth one would like. As a result, most programmes emphasise to students that basic training should be considered as preparation for lifelong learning. A key aspect of the kind of lifelong learning for therapists is that it requires engagement in different types of knowledge (e.g. personal, theoretical, practical, scientific, cultural) and an ability to use insights from different academic disciplines (psychology, neurobiology, anthropology, sociology, humanities, theology, etc.). It is therefore necessary for basic training programmes to introduce students to a wide range of epistemological and disciplinary perspectives.

## **Box 28.1: The use of the arts in training**

In medical education, many teaching initiatives encourage students to read and discuss novels and plays as a means of helping them to engage sensitively, imaginatively, and empathically with the life experience of patients (Boker et al. 2004; Shapiro et al. 2015). Senior therapists have described the importance for them of being able to draw on arts-based knowledge as a resource for both maintaining personal well-being and making sense of complex client issues (Marzillier 2007; Råbu and McLeod 2018). Access to these sources of understanding has the potential to make a valuable contribution to basic therapist training.

## **Post-qualifying training/CPD**

Most professional networks to which therapists are affiliated host one-off lectures, seminars, and workshops that introduce participants to new ideas and also allow them to gain support through

providing opportunities to meet with like-minded colleagues. However, research in fields such as pedagogy and quality enhancement indicates that what is learned in a brief lecture or workshop has only a minimal impact on what therapists do when working with clients. For post-qualifying training to make a difference to practice, it has been found necessary to offer courses in which an initial input is followed up by subsequent supervision and mentoring on an individual or group basis. Increasingly, such courses are using on-line methods such as video conferencing to make this kind of learning experience more affordable and time-efficient for participants (Maitland et al. 2016; Rousmaniere et al. 2014a, 2014b).

Two types of post-qualifying extended training are readily available. One type of course consists of training in specific therapy approaches, such as emotion-focused therapy or the many variants of psychodynamic therapy and third-wave CBT, for therapists who already have skills and experience in some other therapy approach. These courses are widely advertised in professional journals and on the websites of the networks/associations that have evolved to support these individual models of therapy.

The other type of therapy training that is widely available consists of courses designed to overcome discrete areas of therapy difficulties. Examples of this kind of training are the courses run by Crits-Christoph et al. (2006) and others around improving the capacity of therapists to offer an effective therapeutic alliance, and by Hess et al. (2006) on how to respond to angry clients. On the training courses offered by Crits-Christoph et al. (2006), a group of therapists attend a workshop on methods of enhancing their therapeutic alliance with clients, and then receive weekly supervision intended to reinforce the key themes of the workshop. On the training courses run by Hess et al. (2006), participants respond to video vignettes that portray angry clients (e.g. the client expresses anger because the therapist has fallen asleep during the session). Following each video presentation, the therapists receive follow-up training with a supervisor. Similar post-qualifying training has been developed around working with suicidal clients, culturally sensitive therapy, gender diversity-sensitive therapy, and implementing a social justice approach.

In addition to these types of training, the increasing availability of on-line videos, in which experienced therapists demonstrate how they work with clients, has opened up possibilities for therapists to construct personalised competency-oriented programmes of study that are tailored to their own specific needs (Guerry 2016).

## Box 28.2: Responding to suicide

Therapists' basic training always includes some kind of input on how to assess and intervene when a client reports suicidal wishes and plans, and many therapists also attend post-qualifying workshops and courses on this topic. Issues around suicide require counsellors and psychotherapists to work alongside an extensive network of suicide prevention services. Because suicide represents such a tragic and avoidable form of death, governments and voluntary agencies have invested in a wide range of services, including specialist therapy and psychiatry centres, suicide awareness and responsiveness training for members of the public, and helplines, websites, and publicity campaigns. Responding to suicide is probably the area of practice in which societal-level provision has been most fully developed. In other areas of therapeutic work, such as depression, anxiety, trauma, and therapy with specific groups such as young people, some societal-level services have evolved, but not to the same extent as in suicide prevention.

## Supervision

It is a requirement of most professional associations that counsellors and psychotherapists accredited by them should receive regular supervision from a qualified person. In this context, it is necessary to emphasise that supervision has a different meaning from that in other work settings.

Supervision in counselling and psychotherapy is not primarily a management role in which the supervisee is given directions and allocated tasks, but is aimed at assisting the therapist to work as effectively as possible with the client. The supervision role in therapy is therefore similar to that of a tutor or consultant.

Hawkins and Shohet (2012) have identified three main functions of therapy supervision. The first is educational, with the aim of giving the therapist a regular opportunity to develop new understandings and receive information. The second aspect is the supportive role of supervision, through which the therapist can share dilemmas, be validated in their work performance, and deal with any personal distress or countertransference evoked by clients. Finally, they identify a management dimension to supervision, in ensuring quality of work and helping the therapist to plan work and utilise resources. Supervision also plays a crucial role in reviewing and maintaining ethical good practice (Barnett and Molzon 2014). An educational perspective on supervision is emphasised by Carroll and Gilbert (2011; Carroll 2007), who highlight the relevance of different supervisee learning needs and styles, and by Watkins and Scaturro (2013), in their supervision competency framework.

There are a number of different formats for providing supervision. The most common arrangement is to draw up a contract for individual sessions on a regular basis over a period of time with the same person. A variant on this approach is to use separate consultants to explore specific issues – for example, going to an expert in family work to discuss a client with family problems, or using a mental health counsellor for consultation on a client who is depressed. Another possibility is group supervision, where a small group of supervisees meet with a supervisor. The case discussion group is a type of group supervision that gives particular attention to understanding the personality or family dynamics of the client. Peer supervision groups involve a group of therapists meeting to engage in supervision of each other, without there being a designated leader or consultant. Supervision networks consist of a set of colleagues who are available for mutual or peer supervision, on either a one-to-one or a small group basis. In addition to these formal structures and arrangements, most therapists make use of informal supervision with colleagues (Coren and Farber 2017; Farber and Hazanov 2014).

Each of these modes of supervision has its advantages and disadvantages. Regular individual supervision facilitates the development of a good working relationship between supervisor and supervisee. On the other hand, specific consultants will have more experience in a particular area. Group and peer group supervision enable the therapist to learn from the cases and issues presented by colleagues. In these supervision settings, however, there may be problems in maintaining confidentiality and in dealing with the dynamics of the group. The choice of mode of supervision depends on a wide range of factors, including personal preference, cost, availability, agency/employer policy and organisation, and the therapy approach being used.

The supervision process is highly dependent on the quality of information that supervisees bring to the supervision setting. Most often, the supervisee will report what they have been doing with clients, using notes taken after therapy sessions to augment their recollection. If the focus of the supervision is to be on the skills employed by the therapist, the supervisor needs ‘actual data’ from sessions. These data can be obtained from detailed process notes or a verbatim record made immediately after a session, and video- or audio-tapes of sessions. Sometimes, supervisors are able to make live observations of the supervisee working with a client, either in person or using a webcam (Weck et al. 2016). Increasingly, therapists are able to bring client feedback into the supervision process, in the form of data collected through client outcome and process monitoring measures. In some instances, this process becomes a central aspect of supervision, in the form of a ‘deliberate practice’ model of learning (discussed later in this chapter). Some supervisors use creative arts methods to facilitate the process of supervision, with the goal of building a distinctive, playful, and reflective space within which transformational learning may take place (Lahad 2002; Schuck and Wood 2011).

One of the principal dilemmas in supervision is deciding on what it would be helpful to discuss. Potentially, a supervisee might need to explore their understanding of the client, the feelings they



hold in reaction to the client, the appropriateness of different interventions or techniques, and so on. Hawkins and Shohet (2012) have constructed a model of the supervision process that usefully clarifies some of these issues. They suggest that at any time in supervision seven levels are in operation:

- 1 *Reflection on the content of the therapy session.* The focus here is on the client, what is being said, how different parts of the life of the client fit together, and what the client wants from therapy.
- 2 *Exploration of the techniques and strategies used by the therapist.* This level is concerned with the therapeutic intentions of the therapist, and the approach they are taking to helping the client.
- 3 *Exploration of the therapeutic relationship.* The aim at this level is to examine the ways in which the client and therapist interact, and whether they have established a functioning working alliance.
- 4 *The feelings of the therapist towards the client.* In this area of supervision, the intention is to identify and understand the countertransference reactions of the therapist, or the personal issues that have been re-stimulated through contact with the client.
- 5 *What is happening here and now between supervisor and supervisee.* The relationship in the supervision session may exhibit similar features to the relationship between the therapist and their client. Paying attention to this 'parallel process' (McNeill and Worthen 1989) can give valuable insights.
- 6 *The countertransference of the supervisor.* The feelings of the supervisor in response to the supervisee may also provide a guide to some of the ways of seeing the cases that are not yet consciously articulated by supervisor or supervisee, as well as contributing to an understanding of the quality of the supervisor–supervisee relationship.
- 7 *Organisational issues.* Supervision may need to involve discussion around constraints on counselling arising from organisational protocols, the level of support received by the therapist, confidentiality, and other ethical issues and similar topics.

Hawkins and Shohet (2012) argue that good supervision will involve movement between all of these levels. Supervisors tend to have a personal style of supervision in which they stick mainly to a particular combination of levels, and the model can be used as a framework for both supervisors and supervisees to reflect on their work together and if necessary to negotiate change.

The 'cyclical' model of supervision developed by Page and Wosket (2001) pays particular attention to the creation of a 'reflective space' in which the supervisee can explore dilemmas arising from their work, and to the crucial task of applying supervision insights in practice. Page and Wosket (2001) suggest that the process that occurs during a supervision meeting can be divided into a series of stages. Initially, supervisor and supervisee agree a contract for their work together. They then decide on the focus of that session, and 'make a space' for reflection and exploration around that topic or focus. This is followed by 'bridging' – action planning around how new insights and understanding can be implemented in work with clients. Finally, supervisor and supervisee review and evaluate the session together. This series of stages is cyclical, with each completion of the cycle leading to a strengthening of the supervisor–supervisee relationship, and concluding with the negotiation of a new contract.

The stage of training and professional development of the therapist can have an impact on supervision needs. For example, the six-stage model of development of professional identity constructed by Friedman and Kaslow (1986) identifies distinctive supervision themes at each stage of development:

- 1 *Excitement and anticipatory anxiety.* This phase describes the period before the therapist has seen their first client. The task of the supervisor is to provide security and guidance.



- 2 *Dependency and identification.* The second stage commences as soon as the therapist begins work with clients. The lack of confidence, skill, and knowledge on the part of the therapist results in a high degree of dependency on the supervisor, who is perceived as having all the answers. The trainee therapist at this stage will use the supervisor as a model. However, anxiety about being seen as incompetent may lead the supervisee to conceal information from the supervisor. The personality and dynamics of the client, rather than the therapeutic relationship or countertransference, is the most common focus of supervision at this stage, reflecting the lack of confidence and awareness of the therapist in exploring their own contribution to the therapeutic process.
- 3 *Activity and continued dependency.* This phase of development is triggered by the realisation of the therapist that they are actually making a difference to clients. This recognition enables the therapist to be more active with clients, and to try out different strategies and techniques. The therapist is beginning to be more open to their own feeling response to clients. The primary task of the supervisor at this stage is to accept the needs for dependency as well as active autonomy, and to allow the therapist to explore different options.
- 4 *Exuberance and taking charge.* Having acquired considerable experience in working with clients, having read widely in the field, and probably having embarked on personal therapy, the therapist is actively making connections between theory and practice. In supervision, there is a willingness to explore countertransference issues and to discuss theoretical models. The supervisee no longer needs as much support and warmth in supervision, and is ready for a higher degree of challenge. In becoming less dependent on the supervisor, the therapist comes to view the latter more as a consultant than as a teacher.
- 5 *Identity and independence.* Therapists at this stage of development are often attracted to peer supervision with others at a similar stage. The supervisee has by this time internalised a frame of reference for evaluating client work, is in a position to accept or reject the advice or suggestions of the supervisor, and may be aware of areas in which their own expertise exceeds that of the supervisor. It is necessary for the supervisor at this stage to remain available to the therapist and to accept a loss of control.
- 6 *Calm and collegiality.* By now, the therapist has acquired a firm sense of professional identity and belief in their own competence. They are able to take a balanced view of the strengths and weaknesses of different approaches to therapy, and to use peers and supervisors as consultants. At this stage, therapists begin to take an interest in taking on the supervisor role.

The process involved in the formation of a professional identity has the consequence that the focus of supervision can be qualitatively different at succeeding stages. It is helpful for both supervisors and supervisees to be aware that this kind of developmental sequence can take place, and to adjust their behaviour and expectations accordingly.

In each of these models of the supervision process, it can be observed that the quality of the relationship between supervisor and supervisee is of paramount importance. To facilitate this kind of open exploration, it can be valuable to use structured supervisee feedback forms (Wallace and Cooper 2015). As in therapy, the freedom to choose an appropriate helper is valuable, as is the freedom to terminate.

Several studies have reported that supervision can enhance therapists' sense of effectiveness and well-being (Wheeler and Richards 2007). However, in other studies, supervisees have described their supervision as having been counterproductive (Ellis et al. 2014; Gray et al. 2001; Kaberry 2000; Lawton 2000; Nelson and Friedlander 2001). The crucial issue – whether supervision makes a difference to eventual client outcomes – is hard to investigate, because supervision is only one among many factors that may influence the success (or otherwise) of therapy. Only one study has reported clear links between quality of supervision and client outcome (Callahan et al. 2009). Other studies have not been able to replicate this finding (Rousmaniere et al. 2016). The absence of evidence

linking supervision to client outcome appears somewhat counterintuitive; in other fields, such as sports coaching, there is plenty of evidence that the appointment of a new coach may trigger a higher (or lower) level of performance in an individual athlete or a team. However, this kind of case-based outcome study has yet to be attempted within supervision research.

## Enhancing therapist self-awareness

Therapist self-awareness can be viewed as a quality or skill that permeates all aspects of therapist competence. Although self-awareness is addressed within both basic training and CPD programmes as well as clinical supervision, there is a set of structures for supporting therapist competence that focus specifically on enhancing therapist self-awareness. These include such activities as personal therapy, dialogue with colleagues, meditation training, self-practice, and deliberate practice (Knapp et al. 2017a). Research into therapist self-awareness has shown that therapists exhibit a number of types of problematic self-awareness, including being distracted by unhelpful thoughts (Williams 2008). Knapp et al. (2017b) suggest that learning structures oriented towards enhancing self-awareness should help therapists to address the following key questions:

Do I recognise my immediate emotional reactions?

Do I judge my competencies accurately?

Do I recognise my implicit prejudices?

Am I aware that I might succumb to cognitive biases or unhelpful heuristics?

Other self-awareness questions might be added to this list:

Am I aware of how my personal life experience shapes my response to clients?

Am I aware of my levels of wellness and energy and ensuing capacity to be available for clients?

The rationale and underlying purpose of spending time and effort in developing self-awareness around these topics is to use self-awareness as a trigger for building skills and strategies that will make it possible to do a better job with clients. Ideally, effective work on therapist self-awareness comprises a cycle of activity that begins by purposefully engaging in specific ways of being more open to experience, then documenting the awareness that is generated, followed by reflection on these insights, then finally taking action.

## Personal therapy

Personal therapy consists of a counsellor or psychotherapist attending therapy as a client to facilitate their development and well-being, and to address personal issues. Personal therapy can produce a deeper understanding of the client experience and can contribute to a general heightening of self-awareness. Personal therapy can be a valuable means of coping with the stress of the therapist role. Because the agenda of personal therapy is open-ended, it provides a space within which many different facets of self-awareness can be enhanced. Both trainees and experienced practitioners can engage in personal therapy. In addition, many therapists report that therapy they undertook before deciding to enter training had a profound influence on their understanding of therapeutic processes.

Within the counselling and psychotherapy professions as a whole, there is a broad consensus regarding the value of personal therapy. A review of several surveys of the use of personal therapy by counsellors and psychotherapists found that 75 per cent of therapists in the USA (Norcross and Guy 2005) had made use of personal therapy at some point in their career. Within these samples, there was some variation across theoretical orientations, with almost all of the psychodynamic practitioners and around 50 per cent of behaviour therapists having been in therapy at some point, with practitioners of other approaches reporting prevalence rates in between these two figures.

An international survey found that this pattern was found in all countries with mature psychotherapy professions (Orlinsky et al. 2005a, 2005b). On balance, the highest take-up of personal therapy occurred during training, with only around half of therapists re-entering therapy once they had qualified (Norcross and Guy 2005). In these surveys, the reasons that therapists gave for first seeking therapy were fairly evenly divided between training requirements, personal growth, and dealing with personal problems (Bike et al. 2009).

Many training programmes and professional associations require trainees to receive ongoing personal therapy throughout their training. Some fundamental difficulties, however, have been raised by this practice. First, a situation is created where the trainee is required to attend, rather than participating voluntarily. This can create tensions in terms of the trainee's commitment to the therapy process. Second, if the trainee becomes deeply caught up in therapeutic work, it may adversely affect their own emotional availability for their clients. Third, in some traditional psychoanalytic training institutes, the personal therapist is a member of the training staff, and will not only report on the progress of the trainee in therapy but, if the trainee completes the programme, will then subsequently become a colleague of the person who was the client. This situation can create difficult boundary and dual relationship issues. However, the use of personal therapy as an evaluated training component is less prevalent now than in the past. Contrasting approaches to the use of personal therapy in training have been developed within different theoretical traditions, such as psychoanalytic (Lasky 2005), Jungian (Kirsch 2005), humanistic (Elliott and Partyka 2005), cognitive-behavioural (Laireiter and Willutzki 2005), and systemic/family therapy (Lebow 2005).

What is the impact of personal therapy on therapy practice? There are reasons to expect personal therapy to be associated with more competent therapists (e.g. because of greater sensitivity to the client's experience), but also reasons to expect the opposite (e.g. because therapists become preoccupied with their own problems). Studies of personal therapy reflect this balance of views. For example, Buckley et al. (1981) found that 90 per cent of the therapists in their sample reported that personal therapy had made a positive contribution to their personal and professional development. In contrast, Norcross et al. (1988) found that 21 per cent of therapists felt that, for them, personal therapy had been harmful in some way. Peebles (1980) reported that personal therapy was associated with higher levels of empathy, congruence, and acceptance in therapists, whereas Garfield and Bergin (1971) concluded from a small-scale study that the therapists who had not received personal therapy were more effective than those who had.

Evidence around the impact of personal therapy on real client outcomes is inconclusive (Macran and Shapiro 1998; Orlinsky et al. 2005b; Sandell et al. 2000) largely because it is hard to tease out the specific impact of personal therapy from that of other therapist learning processes. However, researchers who have interviewed therapists about their experience of personal therapy have identified many ways in which participants believe that this activity has helped them. For example, Macran et al. (1999) conducted in-depth interviews with seven experienced therapists in Britain, representing a variety of approaches (psychodynamic, person-centred, body-oriented, a eclectic). Three main themes were identified in the analysis of this interview material: *orienting to the therapist* (humanity, power, boundaries), *orienting to the client* (trust, respect, patience), and *listening with the third ear*. Macran et al. (1999) suggest that therapists *translate* their experiences as clients into the 'language' of their practice. In doing this, they use observations of their personal experience (self as client) but also observations they have made of how their therapist operated. It was clear that interviewees were not merely imitating or modelling themselves on their therapists – they learned as much from negative examples as from positive ones. An important source of learning was to figure out how to avoid making the mistakes with their own clients that their therapists had made with them. Similar findings have been reported in other qualitative interview-based studies of personal therapy (Moertl et al. 2017; Probst 2015; Wigg et al. 2011).

In conclusion, although there are debates around the value of mandatory personal therapy for trainees (Chaturvedi 2013), personal therapy is a well-established method for enhancing therapist self-awareness. In a survey of clients, Ivey and Phillips (2016) found that 75 per cent reported that they

would feel more comfortable seeking treatment from therapists who had experienced their own psychotherapy, with only a small minority believing that personal therapy for therapists was not a good idea.

### Box 28.3: The diversity of experiences of personal therapy

Counsellors and psychotherapists are discerning consumers of therapy. In particular, more experienced therapists are able to differentiate between the value of different episodes of therapy that they may have received at different stages in their professional career.

*The Psychotherapist's Own Psychotherapy: Patient and Clinician Perspectives*, edited by Jesse Geller and his colleagues (2005), includes first-person accounts written by well-known therapists, concerning their use of personal therapy throughout their careers. Windy Dryden (2005) described a series of short-term therapy episodes, ranging from psychodynamic group therapy as an undergraduate student, through to Jungian therapy at mid-life. Although he found the majority of these therapies to be unhelpful in addressing certain personal issues, he was also clear that he learned a great deal from this series of therapists, in respect of learning about what to do and not to do as a therapist. By contrast, Clara Hill (2005) wrote about seeing a single therapist for 28 years for a total of 580 sessions, across several therapy episodes. In reflecting on a recent visit, after a lengthy gap, during which her therapist had retired from full-time practice, Hill (2005: 136) noted that 'it is truly comforting to know that she remembers so much of my history . . . her reassurance and caring have kept me grounded'. William Pinsof (2005: 146) described how he entered psychodynamic therapy at the age of 13: 'members of my family had been in analysis before I was born, the works of Freud occupied a central place in our family library'. This therapy was not helpful and it was not until 15 years later that some sessions of family therapy, attended by his wife and parents, allowed him to achieve a breakthrough in his life. Rather than this therapy being part of his training, the choice of family therapy was the result of previous training in that orientation, and using it with his own patients – it was almost as though he needed to see how it worked for other people, before he would be ready to try it out for himself.

The biographical accounts of therapy experiences provided by Dryden, Hill, and Pinsof, and other contributors to this book, act as a reminder that the value of personal therapy, and the meaning it has for the person engaged in therapy, is far from straightforward. To understand and appreciate how and what these individuals have learned from therapy, it is necessary to look at their therapy experiences in the context of their lives as a whole.

## Meditation

Meditation is widely recognised within the therapy profession as a valuable means of learning how to remain centred during stressful moments in therapy, and as a way to develop an enhanced awareness of inner cognitive and emotional processes that are triggered in sessions with clients. In addition to the many therapists who individually engage in training and practice in Buddhist and other forms of meditative practice, many practitioners have been trained in mindfulness techniques in the context of learning about mindfulness-based CBT. More recently, the 'zentsensive' programme has been developed as a specific form of 'intrapersonal skills' training that combines meditation with psychodynamic theory (Goldberg and Sachter 2018).

## Journaling

Many therapists use personal learning journals and other forms of writing to assist self-reflection and the development of self-awareness. Further discussion of this activity can be found in Chapter 16.

## Box 28.4: Theoretical frameworks for therapist self-awareness

Self-awareness is a slippery concept. At one level, everyone knows what it means, but the question of how to pursue or foster it is often unclear. It has proved useful, within therapy training and other forms of therapist personal and professional development, to make use of specific concept frameworks for understanding therapist self-awareness. There have been many initiatives within counsellor training to develop strategies for helping students and trainees actively to embrace the wounded parts of themselves. These conceptual frameworks can be helpful in showing where to look, and why it is useful to look in that particular place.

The idea of 'existential touchstones' (Mearns and Cooper 2005) refers to unique personal strengths that have their roots in specific childhood experiences. For instance, a therapist who was brought up in a family in which emotional sharing and support were not available, but has been able to develop emotional connectedness in their life, is likely to be readily able to appreciate and work with clients who have had similar experiences. Encouraging trainees to identify their 'existential touchstones' can be an effective means of learning how to make productive therapeutic use of one's personal life history and experience.

Another initiative, along similar lines, can be found in the training programme devised by Aponte and Kissil (2014: 156), who ask students to identify their personal 'signature theme', defined as a 'lifelong struggle [that] shape(s) the person's relationships with self and others'. Examples of signature themes generated by members of one class included: 'it's hard for me to stay in my emotions and be vulnerable'; 'I am always thinking the worst; not being able to enjoy the good things but always waiting for the worst to happen'; and 'I am afraid that I am alone or that I will be alone' (Aponte and Kissil 2014: 156). Students are then invited to consider the ways in which their signature themes represent personal resources. Finally, they engage in therapy practice role-play sessions where they actively draw on these resources in their work with clients.

Another widely used self-awareness model makes use of internal family systems theory as a framework for therapist self-exploration (Mojta et al. 2014).

## Self-practice

Self-practice refers to a mode of therapist learning in which the trainee applies ideas and methods from a specific model of therapy to their own life. While this kind of activity has always been an important element within therapist development, formal research into its role initially emerged within the CBT professional community (Bennett-Levy et al. 2001; Gale and Schröder 2014; Gale et al. 2017). By comparing students who had done well in training with those who had struggled, it was found that the former were much more likely to 'try out' CBT concepts on themselves. For example, over a period of time, a trainee might focus on identifying their own unhelpful and self-undermining thoughts and applying CBT techniques to reduce their incidence. The principle of self-practice has been used to inform the design of a series of workbooks for CBT therapists (Bennett-Levy et al. 2015; Farrell and Shaw 2018; Kolts et al. 2018). Although the concept of self-practice has been most fully articulated in CBT, the basic idea is relevant for any approach to therapy, and at any stage in a therapist's career. Self-practice combines self-awareness with the development of practical skills in the context of an overarching theoretical rationale. Compared with other forms of learning through reflection, it therefore offers a more structured and potentially effective mode of enhancing competence.



## Deliberate practice

Debates over the nature of therapist expertise (see Chapter 27), along with evidence that therapists with more experience do not record better outcomes than therapists with little or no experience or training, has stimulated discussion about the adequacy of current approaches to therapist training and supervision. It is reasonable to conclude that while current approaches have value, there is something missing. An influential group of therapy researchers and trainers have suggested that the missing ingredient is 'deliberate practice' (Rousmaniere 2017, 2019; Rousmaniere et al. 2017).

The concept of deliberate practice refers to purposeful, repetitive skills practice outside of the immediate work or performance setting. Intellectually, this perspective has its roots in the work of the Swedish psychologist K. Anders Ericsson into the characteristics of expert performers in many areas of life, such as musicians, chess players, athletes, and surgeons (Ericsson and Pool 2016). This research has shown that while the competence of most members of such occupational groups steadily improves over the course of training, it then hits a plateau and ceases to improve. These are individuals who are engaged in 'practice' (i.e. they do their jobs) with little or no additional commitment to enhancing their abilities. By contrast, there is a smaller group of performers who continue to improve over the course of their career. When Ericsson examined what made these people different, he found that they paid close attention to negative feedback (i.e. when things went wrong), identified the underlying deficit in their skills and knowledge, formulated a strategy for remedying this deficit, engaged in practising these new skills in a safe environment outside of the frontline work situation, and monitored whether all of this had then produced a tangible improvement in their effectiveness in real-life work settings.

Deliberate practice theory explains why most therapy training, supervision, and personal therapy do not yield measurable improvements in therapist effectiveness – they are not structured in a way that allows specific deficits to be identified and worked on. In addition, even therapists who passionately wish to do better for their clients do not possess a coherent strategy for achieving this.

A study by Chow et al. (2015) provides preliminary evidence of the significance of deliberate practice in relationship to therapist effectiveness. In this study, client outcome data were collected across a range of community-based therapy services, for more than 4,500 clients seen by 69 therapists. Between-therapist comparison of outcomes showed a continuum of therapist effectiveness, similar to results from many other studies. The therapists in this study completed a questionnaire that asked them to provide information about their deliberate practice – the amount of time they spent (outside of client hours) on improving their performance as a therapist, the kinds of activities in which they engaged (e.g. supervision, attending workshops, private reflection and study, etc.), and the relevance of each activity. It was found that the most effective group of therapists spent much more time on deliberate practice (average 7.39 hours per month) than their less effective colleagues (2.63 hours per month). There were no clear-cut links between specific deliberate practice activities and effectiveness. However, the activities that were rated by therapists as most relevant were: (a) reviewing difficult/challenging cases alone; (b) attending training workshops for specific models of therapy; (c) mentally running through and reflecting on the past sessions in your mind; and (d) mentally running through and reflecting on what to do in future sessions. While it is important to build on these findings by looking more closely at the value of different practice activities, the study does produce some striking conclusions. First, apart from seeing their clinical supervisor, the less effective therapists were in effect not spending any time on developing their skills. Second, across the sample as a whole, it was not supervision that was viewed as being most relevant in relation to developing skills and effectiveness, but activities that were either a response to negative feedback or activities that involved active practice of new competencies.

At the present time, a number of initiatives are being pursued by different teams around the world regarding how to organise effective learning packages based on a deliberate practice model



(see, for example, Rousmaniere 2017, 2019). Some of these programmes involve integrating a deliberate practice philosophy into routine clinical supervision (i.e. expert guidance), while others comprise learning activities that therapists can pursue on their own. Some organisations are developing methods for enabling groups of therapists in a clinic to work together to enhance their skills and awareness using a deliberate practice approach. In addition, different ways of using technology are being tried out. For example, it is possible to identify critical incidents in video-recordings of work with a client, then practise different ways of responding to that moment (Rousmaniere 2019). With the permission of the client, the supervisor can watch a therapy session live and instruct the therapist in using new skills through a concealed earphone (Rousmaniere 2017). The therapist can practise new skills by responding to a standard set of video triggers of simulated clients enacting typical difficult moments in therapy.

There are many areas of overlap between self-practice (see previous section) and deliberate practice. The starting point for self-practice is more likely to be a therapy theory or a specific concept or technique from a theory. The starting point for deliberate practice is more likely to be feedback from actual work with a client or series of clients. However, in reality, it is hard to disentangle these processes. For example, when a therapist is aware of negative feedback, they quickly start to make sense of it in terms of their theoretical model. Similarly, in self-practice a concept or technique that is chosen for extended personal reflection will likely be something that is connected to a sense that it relates to a gap in how one works with clients. Both deliberate practice and self-practice refer to a personal commitment to use time outside of direct work with clients to improve. Finally, both forms of practice are connected in complex ways with self-awareness activities such as personal therapy, meditation, and journal writing. In many instances, when a therapist engaged in deliberate practice begins to focus on a particular aspect of their work, they may discover that some part of what makes that skill or competency difficult for them can be traced back to unresolved personal life experiences and conflicts.

## Therapist well-being

It takes a lot of energy to be an effective therapist. A central theme in studies of therapist experience and effectiveness is the need for the therapist to be alert and emotionally available over the duration of a therapy session, and to be able to sustain such levels of performance over extended periods of time in respect of a series of regular meetings with a client. In addition, there is an ethical requirement to put the client first – any therapist needs that undermine this principle should be avoided as far as is humanly possible. As a result of these factors, services and activities devoted to therapist well-being represent an important element within the overall provision of services for supporting therapist competence.

As with all organisations, working in a therapy agency can adversely affect the health and well-being of staff. Studies of many different types of organisations have demonstrated that stress and emotional and physical ill-health can be caused by overwork, unplanned change, and a poor working environment. In human service organisations, a specific type of stress has been identified, which has been labelled *burnout* (Leiter and Maslach 2005). The phenomenon of burnout occurs when workers enter a human service profession (such as social work, nursing, the police, or counselling) with high and unrealistic aspirations regarding the extent to which they will be able to help other people. In many instances, the amount of help that can be offered, or the effectiveness of an intervention, is limited by availability of resources, client demand, severity of client problems, and so on. The result is that the helper becomes caught between their own high standards and the impossibility of fulfilling these standards. Following a period of heroic effort to maintain best practice, the worker becomes unable to sustain the effort and energy required to function at such a high level. The various symptoms that accompany this phase can be viewed as comprising a state of 'burnout'.

Maslach and Jackson (1984) identified three main dimensions of the burnout syndrome. People experiencing burnout report emotional exhaustion, persistent fatigue, and low motivation. They also exhibit depersonalisation, gradually coming to see their clients not as unique people with individual problems but as 'cases' or representatives of diagnostic categories. Finally, burnout is associated with feelings of lack of personal accomplishment, or powerlessness. Prevention of burnout has been shown, in a number of studies of different groups of human services personnel, to be linked to the support available from colleagues, realistic workloads, clarity about job roles and demands, variety and creativity in the job specification, and recognition and positive feedback from clients and management (Leiter and Maslach 2005). There have been a number of studies of burnout in counsellors and psychotherapists (Farber and Heifetz 1982; Hellman and Morrison 1987; Jupp and Shaul 1991; Lawson 2007; Lee et al. 2011). These studies suggest that around 20 per cent of therapists display levels of burnout sufficient to require professional assistance and support.

Another type of occupational stress experienced by some therapists is *vicarious traumatisation* (Neumann and Gamble 1995; Pearlman and McIan 1995), sometimes described as *secondary traumatisation* (Morrisette 2004). This type of stress is most likely to occur when therapists work with clients who are suffering from extreme trauma, such as survivors of sexual or physical abuse, refugees who have been tortured, disaster victims, or Holocaust survivors. Therapists working in these areas can often find that they begin to experience intrusive images linked to scenes described by their clients, and other symptoms of PTSD, such as a loss of trust in a safe world. This is an area in which there is a very clear link between the work therapists are doing and the impact it has on their own personal lives. Most agencies offering services to these clients are aware of the danger of vicarious traumatisation and offer appropriate support to staff.

The potential for burnout in therapeutic work is considerable. Therapists are routinely exposed to clients who are in great distress and whose problems do not readily resolve themselves in the face of therapeutic interventions. There are many references in the therapy literature to therapists who have been driven to the very depths of their personal resources through working with particular clients. The high suicide rate of psychiatrists who work with the most highly disturbed clients has been noted in many studies. There is almost certainly a tendency for counsellors and psychotherapists to regard themselves as immune from the effects of work stress, and underestimate its personal impact on them, because of the training they have received.

Alongside these stressful aspects of the role of therapist, there is also evidence that being a therapist has the potential to contribute to personal growth and the enhancement of resiliency (Puvimanasinghe et al. 2015; Wheeler and McElvaney 2017). In developing effective well-being services for therapists, it is therefore necessary to retain a balance between the dual realities of the privilege of accompanying people through difficult periods in their life and the personal costs of doing so.

Preventing therapist burnout and trauma, and addressing them when they occur, is of utmost importance. There are a range of organisational strategies designed to prevent stress and burnout, including regular supervision, opportunities for career development, and involvement in non-clinical roles in training, supervision, writing, and research. Peer support, either within an agency or through training workshops and conferences, and participation in research networks can also contribute to stress reduction. Many therapists make a point of balancing their working lives with taking part in physical activity such as walking, swimming, yoga, and sport. Wicks and Buck (2014) suggest that 'alonetime' should be regarded as a key element of therapist well-being. Many therapists use their own personal therapy to monitor and deal with the stress of their jobs. Cherniss and Krantz (1983) have argued that burnout results from a loss of commitment and moral purpose in the work. This absence of meaningfulness can be counteracted by the establishment of 'ideological communities' comprised of groups of colleagues sharing a set of beliefs and values.

Being able to deal with the stress that accompanies the combined pressures of client work and organisational life represents a core area of therapist competence. A range of books are available

that offer guidelines for therapists on how to cope with the stress of the job (Kottler 1998; Norcross and VandenBos 2018; Rothschild 2006; Skovholt and Trotter-Mathison 2016).

## Career development

There are many different areas of specialisation in therapy, including working with different age groups, social groups, and diagnostic conditions. There are also many different modes of delivery of therapy, such as face-to-face, group, family, on-line, etc. (see Chapter 31). In addition, direct client work can be combined with being a supervisor, trainer, researcher or manager, or with involvement in a professional organisation. Some therapists combine client work with other jobs that they regard as synergistic, such as being a carer, artist, or gardener. There are therefore many alternative work roles that are available to therapists. There is some evidence, from research studies and therapist autobiographies, that therapists are more effective once they have found the occupational niche that best matches their personal interests and gifts and minimises the influence of their anxieties and personal limitations.

The issue of therapist career development is not a topic that has received much attention in the therapy literature. Alongside the task of discovering a professional niche within which one can do good work, there is also the question of how career trajectories are structured – for example, how easy is it to change jobs, engage in further training, or receive career advice? In other fields that are characterised by a multiplicity of specialty roles, such as medicine, and some areas of the arts and sport, there has been a substantial investment in research on career choice and the provision of career counselling and advisory services.

## Institutions

The counselling and psychotherapy professions rely on a range of institutions, including professional bodies such as BACP, the American Counseling Association (ACA), and the Psychotherapy and Counselling Association of Australia (PACFA). These professional bodies fulfil many functions, including accreditation of therapists and training programmes, enforcing ethical standards, promoting scholarship and research, representing the profession in its dealings with government, public relations, and much else. Other important institutions include independent training institutes, university departments, organisations that support specific models of therapy (such as CBT and person-centred), publishers, and service user groups.

Therapy clinics and agencies are also central to the provision of high-quality therapy. Therapist competence is maximised when practitioners work in organisations that provide appropriate levels of support and are oriented towards providing the highest standards of therapeutic practice. The nature and extent of organisational issues in therapy services is discussed in Chapter 31. Although organisational factors in therapy have not been extensively studied, the key message from research to date is that these dimensions can make a significant difference to the quality, accessibility, and effectiveness of therapy that is delivered to clients.

The existence of so many therapy-related institutions illustrates the extent to which therapy practice and effectiveness are shaped by the capacity of those running key organisations to formulate and implement appropriate policies.

## Research

The complex landscape of research in counselling and psychotherapy is reviewed in Chapter 30. Ultimately, the rationale and purpose of therapy research is to enhance therapist effectiveness and

competence. Therapist skills and awareness can be influenced by undertaking research and being a consumer of research studies. Therapist support activities in each of the areas discussed in the present chapter, such as training, supervision, and therapist well-being, are informed by research. The actual everyday work of therapists with their clients is similarly informed by research. Therapy research therefore represents one of the major elements among the societal structures that have evolved as a means of supporting therapist competence.

## Conclusions

This chapter has offered an overview of various professional and societal structures that seek to ensure the effectiveness of therapy that is offered to the public. In evaluating the contribution of these structures and institutions, it is necessary to adopt a broad understanding of the nature of effective therapy. At a societal level, effective therapy does not just mean therapy that results in a reduction in symptoms of anxiety, depression, and other problems. Effective therapy also embraces therapy that is accessible to people from all social backgrounds and is viewed by them as a credible response to their difficulties. While training, supervision, deliberate practice, and the policies of professional bodies are intended to promote excellence, they also exist in order to reduce the incidence of unhelpful or harmful therapy. In addition, from the perspective of the client, there are many ways that therapy may be helpful, beyond symptom reduction.

At the present time, there is little discussion in the counselling and psychotherapy literature around the social ecology of professional therapy. There is a strong underlying assumption within the profession that each therapist is personally directly accountable for the success or otherwise of their work with clients. This assumption represents one of the core strengths of contemporary therapy, because it emphasises the curative significance of a strong alliance, bond, and connection between therapist and client. By contrast, some other forms of help only offer a minimal relationship, or the connection between client and helper is more diffuse and operates at the level of a team approach where there are many helpers. However, it may be argued that this kind of individualized perspective has the effect of directing attention away from collective and societal aspects of therapy provision that are vitally important.

It should be clear from the preceding sections that the professional structures that exist are not particularly well joined up. At a societal level, therapy has evolved in a somewhat anarchic manner, partly influenced by innovation from within the profession and partly by the need to respond to external events and pressures. Politically, economically, and culturally, therapy is not seen to be important enough to require strong regulation and control. Rather, governmental control has been largely restricted to ensuring that the public is not exploited.



### Topics for reflection and discussion

- 1 For each of the support structures and activities highlighted in the present chapter, make a list of the ways in which it might have a *negative* effect on the provision of effective therapy.
- 2 Make a list or map of the various forms of provision that are available within your community to address the issue of suicide. In your view, how comprehensive and effective are these services? How might they be improved?
- 3 Make a list or map of the various forms of provision that are available within your community to address any one of the following issues: depression, sexual violence, relationship difficulties. In your view, how comprehensive and effective are these services? How might they be

improved? How do they compare, in coherence, accessibility, and resourcing, with the services available around suicide?

- 4 What are the professional bodies to which you belong, or that are relevant to your interests as a client or therapist? Inspect the websites of at least two of these organisations. What do the websites suggest to you about the priorities of those bodies? To what extent do you agree that these are the most important issues for those organisations to be concerned with? What other issues might you want them to address?

## Suggested further reading

Valuable collections of papers by leading trainers that explore issues discussed in the present chapter in more depth can be found in the *Journal of Family Therapy* (2005, issue 3 and 2007, issue 4) and the *New Zealand Journal of Counselling* (special issue, 2011). The challenges associated with providing supervision in different contexts are discussed in *Supervision as Transformation: A Passion for Learning* (Shohet 2011). The effort to integrate client feedback and deliberate practice into the therapy process has stimulated important new perspectives around how therapists can be helped to do their best work. The papers in *Routine Outcome Monitoring in Couple and Family Therapy: The Empirically Informed Therapist* (Tilden and Wampold 2017) provide a good introduction to the kinds of debates that are taking place in this area.

# Chapter 29

## Working within an ethical and moral framework

<b>Introduction</b>	<b>446</b>
<b>Sources of ethical knowing</b>	<b>446</b>
Personal intuition	447
Values	447
Ethical principles	449
General moral theories	450
Ethical guidelines developed by professional organisations	451
Human rights, entitlements, and capabilities	452
Relational and process ethics	453
Law	454
Research into professional ethics	454
<b>Applying moral principles and ethical codes: from theory to practice</b>	<b>454</b>
Confidentiality and accountability	455
<i>When the client is at risk of harming others</i>	456
<i>When child protection is an issue</i>	457
<i>When a therapist has an ethical responsibility to society as a whole</i>	458
Negotiating informed consent	458
How far should the client be pushed or directed? The use of persuasion, suggestion, and challenge	459
Working within the limits of competence	461
Managing boundaries	461
<i>Multiple and dual relationships</i>	462
<i>Sexual exploitation of clients</i>	464
<i>Ethical issues involved in the use of touch</i>	466
Ethical issues in research on therapy	467
<b>Strategies for maintaining ethical standards</b>	<b>467</b>
<b>Legal considerations</b>	<b>468</b>



<b>Cultural differences in ethical values and perspectives</b>	<b>468</b>
<b>Conclusions</b>	<b>468</b>
<b>Topics for reflection and discussion</b>	<b>468</b>
<b>Suggested further reading</b>	<b>469</b>

## Introduction

Moral and ethical dilemmas supply the backdrop to everything that people talk about in therapy. Should I finish my course or quit college? Should I stay in a marriage that is making me unhappy? Should I have this baby or arrange for an abortion? Should I come out and acknowledge that I am gay? Shall I take my own life? These, and many other therapy issues, are problematic for people because they involve very basic moral decisions about what is right and what is wrong.

One of the fundamental principles of therapy is that the therapist adopts an accepting or non-judgemental stance or attitude in relation to the client: the intention in therapy is to help the person to arrive at what is right for them, rather than attempting to impose a solution from outside. Nevertheless, at the same time therapy is a process of influence: a client who has benefitted from therapy will look back and see that the therapy process influenced the course of their life. The dilemma for the therapist is to allow themselves to be influential without imposing their moral values and choices. Effective therapists need to possess an informed awareness of the different ways in which moral and ethical issues may arise in their work.

The aim of the present chapter is to provide an introduction to ethical and moral dimensions of therapy. Three broad interconnected themes are explored in the following sections. First, there is an examination of the ways in which moral, ethical, and values dilemmas permeate moment-by-moment therapy practice. It is helpful to view this theme as reflecting what has become known as *relational ethics* – the idea that ethical choices are inextricably bound up with the way that people relate to each other. The second theme refers to professional codes of ethics. As professionals accredited by society to deal with clients who may be vulnerable, needy, and ill-informed, therapists have a responsibility to act towards their clients in an ethical manner, consistent with general cultural principles (such as ‘do no harm’) that are shared with other professions such as medicine and the law.

A third theme consists of the ways that therapists deal with the challenges associated with doing the right thing, at both the micro-process level of relational ethics and the macro-process level of professional guidelines. It is clear that many therapists experience significant amounts of uncertainty and stress in relation to ethical dilemmas. For example, Wendy Austin and her colleagues (2005) have powerfully documented the ‘moral distress’ felt by mental health workers when their moral integrity has been compromised by institutional demands and disagreements with colleagues over ethical issues.

## Sources of ethical knowing

To be able to operate in an ethical manner, it is essential for a therapist to look at difficult situations and choice points from different perspectives. While there may be certain ethical ‘rules’ that can be followed without too much difficulty (for example, ‘do not gossip about clients’), there are also many situations in which the ethically most appropriate course of action is not at all clear. In such circumstances, a therapist needs to be able to compare and balance different ways of knowing. For example, the therapist’s gut feeling or personal intuition may be that a client’s threat to physically harm someone else is just a way of talking about a frustrating relationship, but the ethical procedures specified

by the clinic within which the therapist works may require that any such threat should be officially reported to the relevant authorities. The following sections offer an introduction to some of the key dimensions of ethical knowing that are relevant for therapists.

## Personal intuition

People generally have a sense of what feels right in any situation. This personal moral or ethical response is best understood as intuitive, since it is implicit rather than explicit, and taken for granted rather than systematically formulated. Most of the time, and particularly during a therapy session, therapists rely on their intuitive moral judgement of ‘what feels right’ rather than on any more explicit guidelines. There are, however, a number of limitations or dangers involved in relying only on this way of responding to moral choices.

The first difficulty is that this kind of intuitive response is accumulated through experience. Even for experienced therapists, there may always be a sense in which their personal intuition is incomplete, especially in unusual or unforeseen situations. Other difficulties arise when the personal moral belief or choice of the client is outside the personal experience of the therapist – for example, a Christian therapist working with a Muslim client. It also needs to be acknowledged that there can be occasions when personal intuition can lead to unethical behaviour. For instance, a therapist may feel so threatened by an ethical issue that has arisen, that they lose the capacity to access and trust their inner personal moral compass. At other times, the therapist’s ethical response may be in conflict with other needs or internal voices. A therapist in private practice, for instance, may persuade themselves that a client who pays well would benefit from another ten sessions of therapy.

Despite the limitations of personal, intuitive moral reasoning, it is an absolute essential for therapists. Trainers or tutors assessing candidates for therapist training will be concerned that the people they select are trustworthy, have developed a firm moral position for themselves, and are capable of respecting boundaries. Counselling, psychotherapy, and related occupations represent areas of work where external monitoring of ethical behaviour is extremely difficult, and therefore much depends on personal moral qualities.

## Values

The concept of *values* represents an important conceptual perspective for therapists: ethical and moral issues in therapy are fundamentally connected to questions of values. A ‘value’ can be defined as an enduring belief that a specific end-state or mode of conduct is preferable. Milton Rokeach (1973), a key figure in the study of values, argued that it was important to make a distinction between ‘instrumental’ and ‘terminal’ values. The latter refer to desirable end-states, such as comfort, peace, or freedom. Instrumental values correspond to the means by which these end-states are to be achieved – for example, through competence, honesty, or ambition. The study of values is a complex matter. For example, Rokeach (1973) argues that most people will be in favour of a value such as ‘equality’. As a result, it is not particularly illuminating merely to ask someone whether they identify with certain key values. What is more meaningful is to inquire about their value *preferences*. For example, one person might value equality more highly than freedom, whereas another might feel the reverse.

Many studies have shown that values play an important role in therapy. For example, therapist values tend to influence the values held by clients, which over time are likely to converge with those of the therapist (Kelly 1989; Tjeltveit 2016). This finding raises questions for the practice of therapy. Are therapists imposing their values on clients? Should therapy be seen as a form of socialisation into a particular set of values?

These questions open up an area of inquiry that leads to uncomfortable truths for therapists who portray themselves as value-neutral and non-judgemental. Bergin (1980) argued that the espousal by psychology (and psychotherapy) of scientific beliefs and attitudes was associated with a rejection of religious values. He carried out a systematic analysis of the differences between what he called ‘theistic’ and ‘clinical-humanistic’ value systems. His work made it possible to see that there can be radically

different views of what is 'right' or 'good'. Therapists, trained in institutions that may embody clinical-humanistic values, may perhaps lose touch with the values of at least some of their clients. The power imbalance of the therapy situation may make it impossible for the client to assert their values other than by deciding not to turn up. The issue of value differences is particularly relevant in multicultural counselling, or when the client is gay or lesbian. It is significant that many clients from these groups deliberately seek out therapists whom they know to have a similar background and values.

Research to date on the distinctive moral values of therapy practitioners, and the differences between these values and the values held by many clients, has largely been conducted by administering questionnaires to groups of therapists and clients. However, by using research approaches such as discourse analysis and conversation analysis, it is also possible to explore the process through which moral issues are negotiated between therapists and clients within therapy sessions.

Jarl Wahlström and his colleagues have investigated the ways in which clients may be helped by their therapists to reflect on their moral standpoint in relation to problematic issues in their life. For example, Kurri and Wahlström (2005) analysed the attribution of moral responsibility in a case of couple counselling. They found that each spouse initially adopted a fixed position of blaming the other for causing the problem that was under discussion. In the therapeutic conversation, the therapist consistently reframed what the couple were saying in terms of what Kurri and Wahlström described as a *principle of relational autonomy*, within which each spouse was invited to accept responsibility for their own actions, while at the same time acknowledging that what they were doing happened in the context of what their partner had done or said. This new moral position allowed the couple to create a moral space within which they could begin to find ways to change their actions, rather than being locked into a cycle of mutual blame.

In another study, Holma et al. (2006) analysed changes in the moral reasoning of men taking part in a therapy group for perpetrators of domestic violence. Initially, the men would not accept responsibility for assaulting their wives or partners, claiming that what happened was beyond their control, and due to alcohol, genetics, the emotional nagging of their wife, or other factors. In other words, they were victims. By contrast, the therapists facilitating the group viewed the men as entirely responsible for what they had done. The therapists used two strategies to encourage these men to accept responsibility. First, they created a group environment within which the men could share their experiences in an open and honest manner. This had the effect of bringing feelings of guilt into the open. The second strategy was to invite the men to describe in detail the minutes and seconds leading up to the assault, and to reflect on the choices that were available to them during these moments.

Cushman (1995) argued that moral issues, in the form of questions and decisions around how to live a good life, are intrinsic to all therapy practice, but that most practitioners side-step these issues or re-interpret them in psychological terms. However, it would appear that awareness of the importance of values has undergone a resurgence in recent years (Farnsworth and Callahan 2013; Kirschenbaum 2013; Nahon and Lander 2013). In interviews with expert, highly experienced therapists, Jennings et al. (2005) and Williams and Levitt (2007) found that they were highly sensitive to values conflicts between themselves and their clients and had developed careful strategies for dealing with such situations.

### Box 29.1: The therapist as a missionary for individualism

Brent Slife, one of the leading figures in the area of critical philosophical perspectives on psychotherapy theory and practice, offers a reflective account of his work with Mary, a client in the early stages of his career (Slife et al. 2016). Mary was married, a devout Christian, and depressed. Slife's supervisor advised him that Mary's religious beliefs were not relevant to the process of therapy, and that a scientific, evidence-based approach required that he tackle the case from a behavioural perspective, focusing on sources of reinforcement that made Mary feel happier. For

example, if her relationship with her husband was not satisfying, then it would be useful for her to stand up for what she wanted. If her Church work was frustrating, then she could drop it. In retrospect, Slife was able to see that he functioned with this client as a 'missionary for individualism', seeking to persuade her to adopt the values of liberal individualism, such as happiness, independence, and science. In her own life, Mary operated from a different set of values, in which service to God and the Church was more important than anything else. In the end, the therapy was moderately successful in helping Mary to be less depressed, probably because she lived in a culture in which she had assimilated liberal individualist values alongside her religious belief, with the results that there were aspects of Slife's model of therapy that made sense to her. At the same time, the process of therapy was ultimately not respectful of the client, and ran the risk of undermining a worldview and set of relationships that were hugely meaningful for her.

## Ethical principles

Across all human service professions, there exists a set of general philosophical or ethical principles that underpins and informs both personal and professional ethical codes. Kitchener (1984) has identified five moral principles that run through most thinking about ethical issues: autonomy, non-maleficence, beneficence, justice, and fidelity.

One of the fundamental moral principles in our culture is that of the *autonomy* of individuals. People are understood as having the right to freedom of action and freedom of choice, in so far as the pursuit of these freedoms does not interfere with the freedoms of others. The concept of the autonomous person is an ideal that has clearly not been achieved in many societies, in which coercion and control are routine. Nevertheless, in those societies where counselling and psychotherapy have become established, individual freedom and rights are usually enshrined in law. This concept of autonomy has been so central to therapy that most therapists would assert that therapy cannot take place unless the client has made a free and informed choice to participate, through a process of informed consent: it is unethical to begin therapy, or initiate a particular intervention during the course of therapy, unless the client is aware of what is involved and has given permission to proceed. However, there are many situations in which the concept of autonomy is problematic. For example, although few people would suppose that young children are capable of informed consent regarding the offer of counselling help, it is hard to know the exact age at which a young person is able to give consent. Even with adult clients, it may be hard to explain just what is involved in therapy, because it is an activity that is centred on first-hand experiential learning. Furthermore, the limits of client autonomy may be reached, at least for some therapists, when the client becomes 'mentally ill', suicidal, or a danger to others. In these circumstances, the therapist may choose to make decisions on behalf of the client.

*Non-maleficence* refers to the instruction to all helpers or healers that they must 'above all do no harm'. *Beneficence* refers to the injunction to promote human welfare. Both these ideas emerge in the emphasis in codes of practice that therapists should ensure that they are trained to an appropriate level of competence, that they must monitor and maintain their competence through supervision, consultation, and training, and that they must work only within the limits of their competence.

One of the areas in which the principle of *non-maleficence* arises is the riskiness or harmfulness of therapeutic techniques. It would normally be considered acceptable for a client to experience deeply uncomfortable feelings of anxiety or abandonment during a therapy session, if such an episode were to lead to beneficial outcomes. But at what point does the discomfort become sufficient to make the intervention unethical? Some approaches to therapy advocate that clients ought to be encouraged to take risks in experimenting with new forms of behaviour. The principle of autonomy might suggest that, if the client has given informed consent for the intervention to take place, then they have responsibility for the consequences.

Moral dilemmas concerning *beneficence* are often resolved by recourse to utilitarian ideas. The utilitarian philosopher John Stuart Mill defined ethical behaviour as that which brought about 'the greatest good for the greatest number'. The question of whether, for example, it is ethical to refer a highly socially anxious client to group counselling might depend on whether it can be predicted that, on balance, the benefits of this type of therapy will outweigh the costs and risks. Quite apart from the uncertainty involved in ever knowing whether a therapeutic intervention will be helpful or otherwise in a particular case, the application of utilitarian ideas may conflict with the autonomous right of the client to make such decisions for themselves, or might lead to paternalism.

The principle of *justice* is primarily concerned with the fair distribution of resources and services, on the assumption that people are equal unless there is some acceptable rationale for treating them differently. In the field of counselling, the principle of justice has particular relevance to the question of access to services. If a counselling agency has a lengthy waiting list, is it ethical for some clients to be offered long-term counselling while others go without help? If the agency introduces a system of assessment interviews to identify those clients most in need of urgent appointments, can it be sure that its grounds for making decisions are fair rather than discriminatory? Is it just for a counselling agency to organise itself in such a way that it does not attract clients from minority or disadvantaged groups?

The principle of *fidelity* relates to loyalty, reliability, dependability, and acting in good faith. Lying, deception, and exploitation are all examples of primary breaches of fidelity. The rule of confidentiality in counselling also reflects the importance of fidelity. One aspect of counselling that is very much concerned with fidelity is the keeping of contracts. A practitioner who accepts a client for counselling is, either explicitly or implicitly, entering into a contract to stay with that client and give the client their best efforts. Cases in which the contract is not fulfilled – owing to illness, job change, or other therapist factors – need to be dealt with sensitively to prevent breaches of fidelity.

This discussion of moral principles of autonomy, non-maleficence, beneficence, justice, and fidelity has provided several illustrations of the fact that although these moral ideas are probably always relevant, they may equally well conflict with each other in any particular situation.

## General moral theories

Kitchener (1984) reviews some of the general theories of moral philosophy that can be called upon to resolve complex ethical dilemmas. *Utilitarianism*, the theoretical perspective that was mentioned in relation to beneficence, can be useful in this respect. The application of a utilitarian approach would be to consider an ethical decision in the light of the costs and benefits for each participant in the event: the client, the family of the client, the therapist, and any other people involved. Another core philosophical approach is derived from the work of Kant, who proposed that ethical decisions should be universalisable. In other words, if it is right to breach confidentiality in a particular case, it must be right to do so in all similar cases in the future.

An alternative position developed within moral philosophy has been to argue that it is just not possible to identify any abstract moral criteria or principles on which action can be based. For example, in debates over abortion, some people support the moral priority of the rights of the unborn child whereas others assert the woman's right to choose. Philosophers such as MacIntyre (1981) argue that such debates can never be resolved through recourse to abstract principles. MacIntyre suggests instead that it is more helpful always to look at moral issues in their social and historical context. Moral concepts such as 'rights' or 'autonomy' only have meaning in relation to the cultural tradition in which they operate. A tradition can be seen as a kind of ongoing debate or conversation within which people evolve moral positions that make sense to them at the time, only to see these positions dissolve and change as social and cultural circumstances change. Within any cultural tradition, certain *virtues* are identified as particularly representing the values of the community. For example, in many therapy circles, authenticity is regarded as a primary virtue; in the academic community, by contrast, the key virtue is intellectual rigour or rationality.



From a ‘virtues’ perspective on moral decision-making, the important thing is to keep the conversation open, rather than to suppose that there can ever be an ultimately valid, fixed answer to moral questions. The implications for therapy of adopting a virtues perspective are explored in more detail by Meara et al. (1996), Dueck and Reimer (2003), and Wong (2006). The British Association for Counselling and Psychotherapy’s (BACP) *Ethical Framework for Good Practice* – openly available on the Association website – explicitly draws on a ‘virtues’ perspective by identifying a set of *personal qualities* that all practitioners should possess, such as:

- *empathy*: the ability to communicate understanding of another person’s experience from that person’s perspective;
- *sincerity*: a personal commitment to consistency between what is professed and what is done;
- *integrity*: personal straightforwardness, honesty, and coherence;
- *resilience*: the capacity to work with the client’s concerns without being personally diminished;
- *respect*: showing appropriate esteem to others and their understanding of themselves;
- *humility*: the ability to assess accurately and acknowledge one’s own strengths and weaknesses;
- *competence*: the effective deployment of skills and knowledge needed to do what is required;
- *fairness*: the consistent application of appropriate criteria to inform decisions and actions;
- *wisdom*: possessing sound judgement that informs practice;
- *courage*: the capacity to act in spite of known fears, risks, and uncertainty.

The BACP Ethical Framework additionally suggests that these qualities should be grounded in personal experience rather than approached as a detached, authoritative set of requirements.

### Box 29.2: The practical application of moral theory

A practical approach to applying Kant’s principle of universality to resolving ethical issues in counselling and psychotherapy has been proposed by Stadler (1986), who advocates that any ethical decision should be subjected to tests of ‘universality’, ‘publicity’, and ‘justice’. The decision-maker should reflect on the following questions:

- 1 Would I recommend this course of action to anyone else in similar circumstances? Would I condone my behaviour in anyone else? (Universality)
- 2 Would I tell other therapists what I intend to do? Would I be willing to have the actions and the rationale for them published on the front page of the local newspaper or reported on the evening news? (Publicity)
- 3 Would I treat another client in the same situation differently? If this person was a well-known political leader, would I treat them differently? (Justice)

### Ethical guidelines developed by professional organisations

Counselling and psychotherapy have become increasingly regulated by professional bodies. One of the functions of professional organisations is to ensure ethical standards of practice, and to achieve this objective both have ethical codes or guidelines for practitioners, accompanied by procedures for dealing with complaints about unethical behaviour. All therapists currently in practice should be able to indicate to their clients the specific ethical guidelines within which they are operating.

The Ethical Framework for the Counselling Professions, published by the BACP in 2018, is widely recognised as an exemplary version of what can be achieved by a professional body. Formulated



through a process that involved an expert reference group and consultation with professional stakeholders and members of the public, it is written in plain language and takes as its starting point a powerful statement of intent: 'our aim is to put clients first'.

Although guidelines such as the BACP Ethical Framework are undoubtedly helpful in offering moral leadership and placing on record a consensus view around the ethical issues and dilemmas in counselling and psychotherapy, they are by no means unambiguous. It is of interest to compare guidelines produced by different professional bodies: each code highlights (and omits) different sets of issues, reflecting the fact that it is extremely difficult to formulate an ethical code that can cover *all* eventualities. It is important to note that these ethical codes have been developed not only to protect clients against abuse or malpractice by therapists, but also to protect the therapy professions against state interference and to reinforce its claims to control over a particular area of professional expertise. Ethics committees and codes of practice serve a useful function in demonstrating to the outside world that the therapy house is in order, and that therapists can be relied upon to provide a professional service. They also provide institutional structures within which professional groups can systematically reflect on ethical and moral issues on an ongoing basis, and communicate the current consensus across their membership (and to interested members of the public).

Organisation-level ethical initiatives are not only implemented within professional bodies such as the BACP or the American Psychological Association (APA). Important work is also carried out in counselling and psychotherapy clinics and services, in the form of local practical procedures and protocols for dealing with specific ethical issues such as confidentiality, disclosure of intention to harm, or child protection concerns. Such procedures can have a significant effect on clients and therapists in providing clarity around difficult matters, and establishing that help is at hand for resolving such issues.

## Human rights, entitlements, and capabilities

An important framework for thinking about ethical issues in psychotherapy can be found in the 'human capabilities' model, developed by the economist Amartya Sen (2010), the philosopher Martha Nussbaum (2011), and their co-workers. The concept of human capabilities refers to what people can do and how they can be, in order to live meaningful and satisfying lives. The initial impetus for the model was the debates around international development. Historically, these initiatives have been framed in terms of tangible resources, such as shelter and access to food and water, or measurable objectives such as income or levels of literacy and education. In failing to capture the fullness and depth of what is needed to live a meaningful life, these indicators imply that recipients of development aid are less worthy than people in prosperous countries that supply aid. In addition, they fail to address crucial gender inequalities.

Although the human capabilities approach has not been widely discussed in relation to counselling and psychotherapy (and related activities), there are many aspects of it that are highly relevant. For example, the list of essential capabilities proposed by Nussbaum (2011) includes the following items:

- *bodily integrity*: being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction;
- *senses, imagination, and thought*: being able to use the senses to imagine, think, and reason; being able to have pleasurable experiences and avoid non-beneficial pain;
- *emotions*: being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger; not having one's emotional development blighted by fear and anxiety;
- *practical reason*: being able to form a conception of the good and to engage in critical reflection about the planning of one's life.

A capabilities perspective makes it possible to talk about fundamental human values and needs in a concrete, practical way, rather than a more distanced, abstract fashion. In relation to therapy, these ideas clarify the basic rights and entitlements of clients, and offer a broader context from which to understand the specific therapeutic goals that they seek to accomplish through therapy. It also makes it possible to make connections between the work done by therapists and the efforts of other groups of people who are committed to social justice – a theme that is explored in detail in Chapter 26.

## Relational and process ethics

To a large extent, ethical codes and guidelines produced by professional bodies can be regarded as having a preventive function: they exist to ensure that bad things don't happen to people. Philosophical writings about moral and ethical principles seek to make sense of the meaning of key concepts. A further dimension of ethical reflection comprises the lived experience of acting and responding in the right way. This lived experience is contextual – it occurs in specific situations. It is also relational – it needs to take account of the people involved, their history together, and the world in which they live. Exploration of these issues has been described as *relational ethics* (Gabriel and Casemore 2009). Relational ethics pays active attention to the feelings and emotions of those who are involved, their cultural belief and values, and the question of how mutual respect can be maintained. The application of relational ethics within therapy has the aim of creating an 'ethical space' within which the practitioner and the service user can feel as free as possible to engage fully in a therapeutic process. This endeavour can be regarded as a form of 'positive' ethics, because it aims to make a positive contribution to the quality of the work that is being done. In prioritising the relationship between therapist and client, relational ethics is consistent with the type of ethical stance adopted by many experienced and effective therapists (Jennings et al. 2005).

The existential philosopher Emmanuel Levinas argued that a commitment to the uniqueness and subjectivity of the other person (what he described as 'the otherness of the other') is a key element of relational ethics. This is a profound and highly challenging position to adopt, because it involves not treating the person as an 'object' or a 'case' or assuming that they are the 'same' as oneself (Sayre 2005; Whiting et al. 2005). This is not an easy thing to accomplish as a therapist, when one has been trained to diagnose clients or interpret their actions and problems in terms of relevant theory and research. It finds expression in therapeutic concepts such as 'not-knowing', the emphasis on acceptance and empathy in person-centred therapy, and the pluralistic therapy principle of being open to learning from the client.

A further dimension of relational ethics arises from an appreciation that the client is not merely an autonomous self-contained individual, but also a member of a society that is characterised by injustice, oppression, exploitation, and cruelty. As a result, effective and respectful therapy may involve naming and confronting sources of oppression. This aspect of therapeutic work has been described in recent years as a *social justice* orientation (see Chapter 26), and may involve such activities as supporting a client, where relevant, to engage with groups who are active in opposing oppressive activities such as bullying, sexual violence, racism, and discrimination against people with disabilities. In therapy, relational ethics includes supporting the client to purpose their own values and sense of what can be done to make the world a better place.

Relational ethics highlights the significance of the concept of *care* (Lynch 2007). Caring is regarded as part of the ethical responsibility that all of us hold towards each other and to the planet. An appreciation of relational ethics, therefore, leads therapists to develop a language and consciousness of the centrality of care in their work with clients. At its root, this involves a willingness to say that you care, and to question any signs of an absence of care. Relational ethics also takes seriously the importance of feelings, emotions, and bodily reactions as sources of meaning in respect of ethical issues. Being able to act ethically is not just a matter of being able to resolve ethical dilemmas at a cognitive level but requires a capacity to take account of feelings. For example, a sense that 'this does not feel right' can become a trigger for further reflection.

Taken together, these characteristics reflect an understanding of relational ethics as a *process*. In therapy, confidence around whether one is ‘doing the right thing’ may shift from moment to moment, in response to what is being discussed. In addition, it may take time for the ethical significance of an issue or a therapy intervention to become apparent. This kind of ethical awareness builds on experience and maturity (Carroll and Shaw 2013). Both client and therapist may be sensitive to some ethical issues, and closed to others, on the basis of previous life experience and the need to remain open to ongoing learning. For these reasons, therapists informed by a relational ethical stance do not regard ethical issues as ‘sorted’ once informed consent and boundaries have been agreed. Instead, they engage in a continual process of reflection, checking out, and dialogue to enable client and therapist to retain ethical alignment with one another. The application of a relational ethical stance requires a willingness to integrate ethical awareness, and ethical conversations, into the ongoing flow of therapy. This can have the advantage of ‘normalising’ ethical aspects of therapy: the emergence of an ethical dilemma does not become such a big deal, because it fits into a pre-existing thread of consultation and agreement around similar issues.

## Law

Some ethical issues in therapy overlap with aspects of legal statute, while others do not. For example, statutes exist in most countries that define the conditions under which patient records can be stored and accessed, but no laws around whether therapists can have sex with their clients. It is therefore essential to take account of relevant legal issues when thinking about ethical dilemmas that may arise in therapy. This topic of legal requirements is discussed in more detail in a later section of the present chapter.

## Research into professional ethics

Most of the professional writing about therapy ethics is based on theoretical analyses, proposed guidelines, and case examples. However, there is also a growing amount of research into ethical aspects of therapy, in relation to informed consent, confidentiality, and other issues. Research knowledge provides a valuable source of knowledge, in terms of how clients experience, understand, and evaluate various ethical procedures, and the strategies used by different therapists or therapy agencies to address ethical dilemmas. The present chapter makes reference to research studies that have used a range of methodologies to investigate ethical issues in therapy.

## Applying moral principles and ethical codes: from theory to practice

It would be reassuring to be able to take for granted that someone who is a therapist is inevitably a person of integrity and virtue who acts in accordance with an impeccable ethical code. This is far from being the case. There is ample evidence of ethical malpractice among therapists and psychotherapists. A survey of ethical complaints against credentialed therapists in the USA, carried out by Neukrug et al. (2001), found that 24 per cent of complaints were for an inappropriate dual relationship, 17 per cent for incompetence, 8 per cent for misrepresentation of qualifications, 7 per cent for a sexual relationship with a client, and 5 per cent for breach of confidentiality. These data are brought to life in the cases of therapist abuse of clients vividly described by Bates (2006), Masson (1988, 1991, 1992), and Singer and Lalich (1996).

On the other hand, the overall rate of ethical transgression appears to be low. An analysis of the records of the complaints department of the BACP found that, on average, only about 15 actionable complaints were received each year (Khele et al. 2008; Symons et al. 2011). Male therapists were more likely to be complained against than their female colleagues, and the source of more than half of the

complaints was a member of the profession or a trainee, rather than a member of the public. This low rate of complaints, and the fact that complaints predominantly were made by people in the profession who were familiar with the system, raises questions about whether the procedure for making a complaint (at the BACP and other similar bodies) acts as a barrier to aggrieved clients taking action.

Symons (2012) carried out a survey of therapy clients who had been the subject of an ethical breach by their therapist, but had chosen not to make a complaint. When asked what had stopped them from pursuing their complaint, many stated that they would have preferred some form of mediation rather than a formal tribunal, and that it would come down to 'his word against mine'. The BACP is to be commended for its transparency in commissioning this research. What it shows is that it is in fact hard to determine, with any certainty, the extent of ethical misconduct in counselling. The cases discussed in the present chapter are the tip of the iceberg, because they have received wide publicity. Beyond that, the records of professional associations represent the visible part of the iceberg. It is inevitable that there is more beneath the surface – but no one knows how much more.

The question of the ethical basis of therapy practice is not merely a topic for theoretical debate, but a matter of immediate concern for many therapists, clients, and managers of therapy agencies. In order to function in an ethically acceptable manner, there are a series of key issues that therapists need to consider:

- confidentiality and accountability;
- negotiating consent;
- the limits of persuasion;
- dual relationships;
- sexual attraction between therapist and client;
- using touch.

Ethical good practice requires that therapists and therapy organisations need to be aware of the kinds of ethical challenge associated with each of these areas, and develop strategies for responding to them if and when they occur.

## Confidentiality and accountability

The confidentiality of information disclosed by a client to a therapist represents a fundamental cornerstone of therapeutic practice. Effective therapy depends on the creation of a safe therapeutic space in which the client is able to share experiences that may be embarrassing, shameful, irrational, or speculative. Careless leakage of information to others, such as family members or employers, carries the risk of both emotional and material damage to the client. Therapists and therapy agencies devote considerable effort to ensuring that robust confidentiality procedures are in place – and are explained to the client. However, there are some circumstances in which confidential client information may need to be communicated to others, such as when a client has expressed an intention to harm themselves. Although standard practice in response to such a disclosure involves exploring options with the client, most therapists would regard the preservation of life as the highest level of ethical imperative, and if necessary would enlist crisis assistance for the client even in the face of opposition to such a course of action on the part of the client.

The underlying ethical issue here is that of therapist accountability. On whose behalf is the therapist working? Is the therapist only the agent of the client, only acting on behalf of the client? Or, are there other people who have legitimate demands on the allegiance of the therapist? Traditionally, many therapists have attempted to espouse a rigorous 'client-centred' ethos. Nevertheless, there are many situations where absolute client-centredness may not be morally and ethically the correct course of action. A workplace therapist being paid by a company may be under pressure to achieve a particular result with a client, or to report back on the client's fitness to work. A therapist working with an adolescent may find the parents offering suggestions or seeking information. In marital

therapy, is the therapist accountable to one or other spouse/partner, or to their relationship? To what extent is the therapist accountable to the children of a marriage?

The scenarios outlined above can usually be addressed through a careful process of contracting at the start of therapy, through which negotiation takes place between the therapist and key stakeholders regarding the confidentiality boundaries that are required, and are acceptable, in any particular case. Two further scenarios that are particularly hard to manage are when the client is at risk of harming another person, or where the client discloses information about child abuse. Such episodes tend to emerge without warning, in the ongoing process of therapy. It is unlikely, therefore, that the client–therapist agreement or discussion around confidentiality at the start of therapy would be sufficiently detailed to provide clear guidance on what should then happen. There is the added pressure that the involvement of external organisations, such as the police or social services, might lead to consequences that are extremely hard to predict.

### *When the client is at risk of harming others*

Some of the most painful and difficult dilemmas around accountability arise in relation to the therapist's 'duty to warn and protect' in cases where their client threatens violence to another person. The difficulties arising from such a situation are illustrated by the well-known *Tarasoff* case (Bersoff 2014; see Case study 29.1). Issues associated with the 'duty to warn' of the therapist are also encountered in AIDS counselling, mainly around the disclosure of HIV status to sexual partners of the client (Alghazo et al. 2011; Costa and Altekruze 1994; McGuire et al. 1995). Similar issues arise in situations in which clients have disclosed information about unprosecuted murder and sexual violence with which they have been involved in the past. A survey carried out by Walfish et al. (2010) found that as many as one in three therapists has encountered such a dilemma at least once over the course of their career.



### **Case study 29.1: The 'duty to protect and warn' – ethical dilemmas arising from the Tarasoff case**

In August 1969, Prosenjit Poddar was a voluntary outpatient at the university health service in Berkeley, California, receiving therapy from a psychologist, Dr. Lawrence Moore. Poddar had informed his therapist of his intention to kill his girlfriend, Tatiana Tarasoff, when she returned from a trip to Brazil. In consultation with two psychiatrist colleagues, Dr. Moore recommended that Poddar be committed to hospital for observation but was overruled by the chief of psychiatry. Poddar moved into an apartment with Tatiana's brother, near to where she stayed with her parents. Dr. Moore wrote to the chief of police asking him to confine Poddar, and verbally asked the campus security service to detain him if he was seen. They did so. Poddar assured the campus officers that he meant no harm, and they released him. Poddar subsequently murdered Tatiana Tarasoff. No warning had been given to either the victim or her family. The chief of psychiatry asked the police to return the letter written by Dr. Moore and directed that the letter and case notes be destroyed. The University of California was sued by the parents of Tatiana Tarasoff, on the grounds that they should have been warned of the danger to their daughter. The defence stated that, after Poddar had been involved with the police, he had broken off all contact with the hospital, and was no longer one of their patients. A lower court rejected the case, but on appeal a higher court found for the parents.

The outcome of this case clearly carries a number of implications for counsellors and psychotherapists. It is widely accepted that therapists need to be willing to breach client–therapist confidentiality when the safety of others is at risk. Therapists need to do everything possible to 'warn and protect' those in danger from their clients. Many US states have enacted laws that make the failure to protect a criminal offence. Therapists should be able to assess accurately and reliably

the potential dangerousness of clients. Finally, counselling and psychotherapy agencies must enact specific policies and procedures for dealing with such cases.

The Tarasoff case demonstrates some of the complexities of ethical decision-making, and how ethical considerations can affect the therapy process itself. The right of the client, Prosenjit Poddar, to respect for his autonomy and for the confidentiality of his disclosures to his therapist was in conflict with the fundamental duty to protect life. The information about his intention to kill his girlfriend was shared with his therapist because they had a strong therapeutic relationship, but this relationship was destroyed by the action taken in an attempt to prevent violence. The therapist himself was faced with contradictory advice and guidance from professional colleagues. The situation necessitated him liaising with the police, a course of action that he had not been trained to undertake effectively.

Many clients express anger and resentment towards others in therapy sessions. From some theoretical perspectives, such episodes can be interpreted as 'cathartic' and beneficial. On the other hand, as the Tarasoff case and many other such cases have shown, there are occasions when such client intentions are turned into action.

The Tarasoff case continues to stimulate debate over the meaning and implications of the therapist's 'duty to protect and warn' (Bersoff 2014; Kadooka et al. 2016).

Frankel and Mitchell (2012) have outlined some principles that may be helpful for therapists when a client is threatening violence to another person. An important strategy is to be willing to address the issue directly with the client, so that they can register the concern being felt by the therapist. It is also necessary to conduct a risk assessment, focusing on factors such as the existence of a specific intent, as against vague wishes and feelings, whether planning has taken place, and whether the client is actually able to carry out the attack. One of the aims here is to establish whether the person is capable of self-control and of working with the therapist (and possibly others) to defuse and manage the threat. In addition, Frankel and Mitchell (2012) advise that the therapist should consult with professional colleagues and their professional association, as well as document everything that is discussed. The purpose of consultation and documentation is not only to safeguard the therapist in case of a future complaint or inquiry, but also to support their sense of confidence and competence in a scenario in which they could become paralysed with self-doubt and indecision, to the extent that undermines their therapeutic skills and capacity to maintain an alliance with the client.

These guidelines are similar to the kind of strategies that have been developed for responding to other in-session ethical crises. They consist of a mix of skills that a therapist would be likely to use anyway in everyday practice, and actions (e.g. consultation with the professional association, followed by personal appraisal on whether or how to implement what they suggest) that the therapist may have had few prior opportunities to practise. One of the key difficulties for the therapist is that a therapeutic process that has up to that point been contained within the therapy hour, has suddenly spilled out into something else. All this is happening during a time when the therapist may be experiencing a high level of moral responsibility and personal anxiety. In the midst of all this, the therapist needs to make an important decision (to report and act, or to continue with the therapy) that may have big consequences. It is therefore possible to see that what has been described as 'the duty to protect and warn' has the potential to be a highly complex task, which draws on basic therapeutic skills, the capacity to understand and implement ethical principles, and the availability of professional and organisational support.

### *When child protection is an issue*

Another area of therapy that is associated with major dilemmas around accountability is disclosure of information about current or past emotional, physical, or sexual abuse or harm to a child



or vulnerable adult. In many countries and therapy organisations, there is a legal requirement on the therapist to report instances of child sexual abuse to the appropriate legal authority. If a client tells the therapist that they have been abused as a child, or that their children or the children of a neighbour are being abused, the therapist must then make a difficult decision about when and how to report this information to the authorities. Any move of this type clearly has profound implications for the relationship between the client and therapist. It also has implications for the ways that therapists and therapy agencies carry out their work. For example, it becomes necessary to inform clients at the start of therapy that the therapist would need to breach confidentiality in such circumstances.

Research into the experiences of therapists around the process of mandatory reporting of child protection issues suggests that this is one of the most difficult and anxiety-provoking situations with which any therapist is called upon to deal with (Duncan et al. 2015). Therapists fear that the therapeutic relationship will be fractured if they act on the information received, and they fear for the consequences for the client, the young person who has been abused, and for their own professional reputation (Bean et al. 2011; Brown and Strozier 2004; Strozier et al. 2005). Although guidelines exist that outline the steps and tasks that a therapist should follow when they encounter disclosure of abuse (Henderson 2013) and training programmes have been developed (Alvarez et al. 2004), there is no evidence to date that such strategies really make a difference to therapist competence or comfort in such situations.

### *When a therapist has an ethical responsibility to society as a whole*

The ethical accountability of therapists can stretch beyond situations that concern the immediate provision of therapy. In 2008, Kenneth Pope, a psychologist who is a leading international figure on ethical issues in therapy, resigned from the APA in protest against what he regarded as its inadequate response to the involvement of psychologists in detainee interrogation in settings like the Guantanamo Bay Detainment Camp and the Abu Ghraib prison (Bond 2008). Elsewhere, counsellors and psychotherapists have drawn attention to the injustices experienced by refugees. These examples function as a reminder that there exists a level of collective responsibility, within a professional group, that operates in addition to the personal responsibility of individual members.

## **Negotiating informed consent**

The use of *informed consent* represents one of the main strategies for ensuring that ethical principles are reflected in practice. Informed consent involves providing the client with accurate and adequate information about the therapy that they are being offered, and other alternative therapies that might be available. The person is then allowed sufficient time to make up their own mind, is offered an opportunity to ask questions, is not subjected to any kind of coercive pressure, and then makes a decision that forms a contract or binding agreement between themselves and the therapist. In practice, there are a number of difficulties involved in achieving a satisfactory consent procedure (Barnett et al. 2007; Beahrs and Gutheil 2001). These include:

- making information available in a form that the client will understand;
- using time that could otherwise be devoted to therapy;
- providing information that will cover every eventuality in therapy (i.e. all the different techniques or therapeutic strategies that might be employed);
- collecting up-to-date accurate information about the alternative treatments that are (a) in principle available and (b) available within the locality;
- conveying information about alternatives in an even-handed manner, rather than steering the client in the direction of the therapist's preferred approach;
- knowing whether the client is genuinely in agreement, or is merely deferring to what they regard as the superior wisdom of an expert therapist.

A valuable principle, in relation to these issues, is to adopt a strategy of *process consent*: rather than assuming that informed consent is only a matter to be dealt with at the start of therapy, the practitioner routinely checks out with the client, on a regular basis, whether they feel they have sufficient information and are satisfied with the course that is being taken in therapy. In a survey conducted by Pomerantz (2005), psychotherapists in the USA were asked to indicate the point in therapy at which they typically discussed a range of consent issues. They reported that they usually discussed contractual/business issues such as payment, missed appointment arrangements, and confidentiality with clients in the first meeting, negotiated most other consent issues in the second session, but were not in a position to agree the length of therapy until at least the end of the third session.

In reality, full informed consent is an ideal that is difficult to achieve. It may be hard for some clients to enter a counselling relationship at all, and there is a danger that some people might be deterred by receiving a mass of detailed information during or at the end of their first meeting with a therapist. Some clients may be too upset or traumatised to assimilate informed consent information. Other clients may not understand what it means. On the other hand, there is evidence that most clients have questions about therapy they want answers to (Braaten et al. 1993). Many therapists and counselling agencies provide clients with a leaflet explaining the principles of their therapy, outlining practical arrangements and informing them of complaints procedures. Handelsman and Galvin (1988) and Pomerantz and Handelsman (2004) have proposed that therapists and therapy agencies should provide clients with a list of questions they should ask their therapist, with time being set aside for this.

### Box 29.3: Informed consent in action

Informed consent is one of the bedrock principles of ethical best practice in healthcare, business, and many other sectors of life in addition to counselling. The literature on informed consent highlights the key principles around which meaningful informed consent is constructed. But what happens in practice? How do therapy practitioners actually deal with the informed consent process? O'Neill (1998) interviewed a number of therapists and clients in Canada about their experiences of negotiating consent. What he found was a broad spectrum of practices. Some therapists based their approach around a collaborative consensual stance in which all possible options were explored. In contrast, other therapists adopted a more 'take it or leave it' stance. The clients who were interviewed by O'Neill (1998) overwhelmingly wanted more choice, more information, and to be more involved in the process of deciding on what kind of therapy was best for them. The study by O'Neill (1998) offers a rich account and discussion of the complexities of informed consent in practice. Overall, his findings suggest that the majority of therapists do not adequately address consent issues and that, as a result, a sizeable minority of clients are either dissatisfied with the therapy they receive or drop out.

### How far should the client be pushed or directed? The use of persuasion, suggestion, and challenge

There is a fundamental ethical tension in counselling and psychotherapy around the definition and perception of the role of the therapist. In the client-centred/person-centred and psychodynamic traditions, the position taken is that the role of the therapist is to be reflective and allow the client time to arrive at their own understandings and insights. There is another tradition, however, which favours a much more active stance on the part of the therapist through the use of interventions that attempt to accelerate the pace of change or force breakthroughs.

It is not difficult to find examples of over-confrontational therapy that becomes abusive (Singer and Lalich 1996). 'Direct psychoanalysis', developed by the psychiatrist John Rosen, included the use of physical violence, verbal assault, deception, and imprisonment (Masson 1988). In the Centre for Feeling Therapy, therapists engaged in physical and verbal violence, and also encouraged extra-marital affairs among couples who were in therapy (Lakin 1988). The leading figures in both these enterprises were sued by patients and debarred from practice. Although the levels of abuse and cruelty to clients exhibited in these cases were outrageous, it is important to note that the founders of these therapies were highly qualified and trained, had published widely, and had been commended by leaders in their profession for their pioneering work. Although the psychotherapy profession has largely moved away from the use of actively confrontational techniques, there is evidence that contemporary variants of such approaches are still deployed in some settings, such as compassionate confrontation psychotherapy for young people (Bratter 2011).

These examples of confrontation and challenge illustrate very direct and overt attempts to control clients, to modify their beliefs and behaviour. A much subtler form of therapist control is implied by the issue of *false (or recovered) memories* of childhood sexual abuse. Most therapists are familiar with the experience of working with a client who seems suddenly to remember events from the past – for instance, memories of abuse or humiliation – that had been hidden for many years. Given that the events being recalled are in the distant past, and that quite possibly no independent or objective evidence exists as to whether they actually happened or not, there is often an issue as regards whether these memories are genuine or are perhaps false and manufactured.

This is not space here to review the vast literature on the veracity or otherwise of recovered memories of childhood abuse. This is a topic that has generated a great deal of research and debate, within the field of cognitive psychology of memory as well as within psychotherapy. The development of knowledge and understanding around the recovered memory phenomenon in therapy can be tracked through Enns et al. (1995), Spence (1994), McNally and Geraerts (2009), and Laney and Loftus (2013).

The point is that there are important psychotherapeutic as well as ethical issues associated with the responsibilities of therapists around any process of tentative remembering of traumatic events in the process of therapy. This is a very sensitive and complex topic. Many clients believe that they possess hidden memories of bad things that have happened to them, and that it would be useful to bring them into the open (Rubin and Boals 2010). Evidence-based models of the trauma process exist that explain how memories of traumatic events become encoded in physiological bodily states, and are capable of being released when the person accesses relevant emotions (Milchman 2008; Rothschild 2000, 2017). Nevertheless, if a therapist interprets vague memories as indicators of prior trauma and abuse, and is wrong, they can end up being the instigator of great harm to an individual and their family. If, on the other hand, a therapist avoids drawing conclusions about abuse, or naming the abuse, or exploring the possible meaning of vague memories, the effect on the client can be equally damaging. The connection between the use of a therapy technique and its ethical consequences is very clear in this type of case. How actively should a therapist interpret the client's experience? Should the therapist wait until there is overwhelming evidence to support the interpretation? Under what circumstances are clinical intuition and 'hunches' allowable?

The use of therapist challenge, confrontation, and suggestion is not restricted to the kind of clear-cut scenarios discussed earlier. When therapists use concepts such as 'resistance', 'defence', and 'lack of insight', the implication can often be that it would be helpful to use pressure to break through barriers. While many clinicians approach such situations in a collaborative and respectful manner (see, for example, Sommers-Flanagan et al. 2011), there is also a great deal of evidence that therapists are able to use language in subtle ways to bring clients round to their point of view (Davis 1986). There is also evidence that, during therapy sessions, clients show deference to their therapist (Rennie 1994a) and find it very hard to tell their therapist when they are unhappy with an intervention that is being pursued (Blanchard and Farber 2016; Bowie et al. 2016). It is therefore important to appreciate that therapist misuse of power is not restricted to cases that end up being referred to

professional standards boards but is potentially an intrinsic part of routine practice. In this sense, such issues need to be considered from the standpoint of relational ethics, as much as – or even more than – a perspective of formal ethical guidelines.

## Working within the limits of competence

A central aspect of ethical practice comprises a commitment to provide the best possible service to the client. This requires that therapists work within the limits of their competence, such as not using interventions or working with problems or client groups for which they lack adequate training. It also requires therapists to actively engage in ongoing personal and professional development and to ensure that their own energy levels, health, and well-being are sufficient to allow them to be fully available and present to clients. Further discussion of the nature of professional competence can be found in Chapter 27.

## Managing boundaries

The concept of ‘boundary’ refers to the point of contact between two regions of social life. There are many boundaries that exist within the therapy relationship, such as the time boundary that marks the start and end of a session. There are also information boundaries (what the therapist knows about the client and vice versa) and geographical boundaries (meeting in the therapy room versus meeting in an everyday setting). A paper by Gutheil and Gabbard (1993) is widely regarded as making a decisive contribution to the analysis of boundary issues in therapy. The key points made by Gutheil and Gabbard (1993) were:

- recognition of multiple boundaries – role, time, place and space, money, gifts, services, clothing, language, self-disclosure, and physical contact;
- a distinction between boundary ‘crossings’ and boundary ‘violations’; and
- the idea that the management of boundaries in therapy always consists of some combination of two factors: technical and ethical.

A technical perspective refers to the issue of whether an action represents good therapy that is helpful for the client. For example, allowing a session to run 30 minutes over time may or may not be helpful for the client (technical issue) and may or may not be an ethical issue (breach of consent, doing harm by raising unrealistic expectations). Gutheil and Gabbard (1993) argued that understanding whether a boundary crossing is helpful or not (i.e. a violation) always requires careful analysis of the context within which it occurs. A useful discussion of these issues can be found in Hermansson (1997).

The work of Gutheil and Gabbard (1993) has subsequently developed in two directions. The understanding of boundary management in the therapy professions has been strengthened by studies of specific boundary issues, such as being asked to provide client information to the courts (Borkosky and Smith 2015) and how to handle instances where the therapist meets a client outside of the therapy room (Lauka et al. 2013; Pietkiewicz and Włodarczyk 2015). A current area of concern for many therapists refers to information available on the internet. There is evidence that as many as 50 per cent of therapists search the internet for information about their clients (Kolmes and Taube 2014), while many clients search for personal (i.e. not professional) information about their therapist (Kolmes and Taube 2016). Some of this behaviour can be harmless or even helpful, but virtually none of it is covered by pre-existing mutually agreed consent. The stalking of their therapist by a client represents an extreme manifestation of such searching. A survey of therapists in Germany found that around one in four had been stalked by a client at some stage in their career (Praus et al. 2018). Stalking of clients by their therapist (and equivalent behaviours such as sexual grooming) is not unknown.

The other direction triggered by Gutheil and Gabbard (1993) has been the publication of guidelines for therapists around how to manage boundaries. A particularly useful set of guidelines, which

suggest various questions that therapists might ask themselves when boundary management dilemmas arise, can be found in Pope and Keith-Spiegel (2008). Frankel et al. (2012) have analysed strategies used by experienced therapists when faced with boundary challenges.

From an ethical perspective, therapy boundaries that are particularly problematic are dual relationships and sexual contact. These issues will now be discussed.

### *Multiple and dual relationships*

Dual or multiple relationships in counselling and psychotherapy occur when the therapist is also engaged in another (or more than one) different type of relationship with a client. Examples of dual relationships include: being a therapist to someone who is a neighbour, friend, or business partner; accepting payment from a client in the form of services (e.g. childminding); or being the landlord to a client.

Pope (1991) has identified four main ways in which dual relationships may conflict with effective therapy:

- 1 Dual relationships compromise the professional nature of the relationship. Therapy depends on the creation of an environment of emotional safety created in part by the construction of reliable professional boundaries, and the existence of dual relationships makes these boundaries unclear.
- 2 Dual relationships introduce a conflict of interest: no longer is the therapist there solely for the client.
- 3 The therapist may be compromised in respect of entering into a business or other non-therapy relationship on an equal footing, owing to personal information the client has disclosed and/or the likelihood of transference reactions, such as dependence.
- 4 If it became acceptable for therapists to engage in dual relationships after therapy had terminated, it would become possible for unscrupulous practitioners to use their professional role to set up relationships engineered to meet their needs.

These factors can be summarised in terms of two broad dimensions of risk. Dual or multiple relationships open up the possibility of exploitation of the client in contexts outside of the therapy room. Such relationships can also 'muddy the water' in respect of contributing to confusion around what is happening within the process of therapy itself.

Research on the prevalence of dual relationships has shown that around one-third of therapists have at some time developed non-sexual non-therapy relationships with current or former clients (Lamb and Catanzaro 1998; Pope 1991; Salisbury and Kinnier 1996). For example, Lamb and Catanzaro (1998) found that more than half of the therapists in their survey had engaged in 'going to a client's special event' (e.g. wedding, funeral of family member, art show).

The possibility that dual relationships might have a highly destructive impact on the capacity to conduct effective therapy has resulted in many therapists and psychotherapists adopting a stance that therapy is impossible if there is a dual relationship. On the other hand, there are many circumstances in which dual relationships are unavoidable. Many therapists in schools and colleges are also employed as teachers or tutors. Therapists operating in the police or armed services may be required to fulfil other roles, such as critical incident de-briefing, training, and serving on promotions panels. Therapists in recovery from addictions may be engaged in working with clients with the same set of problems or meet at a 'twelve step' meeting. Within small rural communities (Gonyea et al. 2014; Schank and Skovholt 1997), there may be little or no choice of therapist. Brown (2005) has described her experience as the most experienced feminist therapist in her city and the inevitability that younger colleagues would approach her for personal therapy.

Recognition that it is feasible to carry out ethical and effective therapy in the context of a dual relationship has resulted in a reappraisal in recent years of an absolute ban on this kind of practice (Gabriel 2005; Moleski and Kiselica 2005; Zur 2017). Moleski and Kiselica (2005) have introduced



the useful concept of a *continuum* of dual/complex client–therapist relationships, ranging from the therapeutic to the destructive. The advantages of dual relationships include the possibility – for example, in a rural community – that a person is able to make an informed choice of therapist based on some level of prior acquaintance with them, or as a result of their reputation within the community. A further advantage may be that, at least in some cases, multiple relationships between clients and therapists reflect the existence of a caring social network.

Guidelines are available for managing multiple or dual relationships in therapy (Everett et al. 2013; Lamb and Catanzaro 1998; Pope 1991; Salisbury and Kinnier 1996; Younggren and Gottlieb 2004; Zur, 2017). These guidelines recommend therapist transparency in relation to openly discussing with the client if there is any possibility of a dual relationship, establishing an explicit treatment plan that clarifies the work of therapy as distinct from any other type of client–therapist contact, agreeing ground rules for meetings that might take place outside of therapy sessions, writing down what is discussed and agreed, and using supervision.

In conclusion, it is apparent that the therapy professions have moved beyond policies that advocated absolute therapeutic boundaries. There is an appreciation of the unhelpfulness of what Everett et al. (2013) have characterised as ‘negative and unfriendly self-surveillance’, where therapists beat themselves up, and lose their common sense, if any hint of a dual relationship becomes apparent. Instead, the emerging consensus in the contemporary professional literature is that while there are many instances in which dual/multiple relationships with clients can be deeply unhelpful (Keith-Spiegel 2013), it is also possible to engage creatively and constructively with multiple relationship scenarios, and even turn them to therapeutic advantage.

### **Box 29.4: Conducting therapy with a prominent member of a remote rural community**

A case report by Curtin and Hargrove (2010) offers a detailed account of therapy with a hospital doctor who was suspended following complaints about his outbursts of anger towards colleagues and required to attend psychotherapy as part of his rehabilitation and probation. Only one psychotherapist was available in the rural community in which the doctor resided – the nearest alternative source of therapy was 100 miles away. The therapist had prior knowledge of his client through a variety of sources. They were members of the same Church, had children of the same age, and had many mutual contacts. Most notably, the therapist had previously provided treatment to the client’s mother. In this case, the therapist employed a range of strategies to manage the multiple relationships that encircled the therapy. He engaged the client in a lengthy informed consent process at the start of therapy, where they discussed the significance and potential impact of their multiple relationships and returned to these issues at various points throughout the course of therapy. He constructed a case formulation and treatment plan that was agreed with the client, which specified the work they would do together. He was cautious in what he said in relation to particular topics, such as not disclosing that he had been a therapist for the mother of the client. The therapist kept careful notes for himself to clarify the distinction between information that had been provided by the client and what he knew from other sources. The therapy was highly successful, despite the fact that the key issues explored by the client comprised alcohol abuse and family dynamics that overlapped with areas of knowledge about the client that were already known to the therapist through other channels. The therapist believed that he was assisted in his work with this client by a close understanding of personal pressures associated with the client’s prominent role in the community.



### *Sexual exploitation of clients*

In a highly influential book, the feminist psychologist Phyllis Chesler (1972) documented cases of sexual relationships between male therapists and their clients, vividly portraying the emotional damage caused by such behaviour. Subsequently, a number of surveys of psychologists and psychotherapists reported that sexual contact between therapists and their clients was not uncommon, despite being explicitly prohibited by all professional codes of conduct. In a survey of 1,000 psychologists in the USA, Holroyd and Brodsky (1977) found that 8.1 per cent of the male and 1.0 per cent of the female therapists had engaged in sex with clients. Some 4 per cent of their sample believed that erotic contact with clients might in some circumstances be of therapeutic benefit to the client. Pope et al. (1979) carried out a similar anonymous questionnaire survey of 1,000 psychotherapists and found that 7 per cent reported having had sex with a client. Finally, Pope et al. (1986), in another large-scale survey of American practitioners, revealed admission of erotic contact with clients by 9.4 per cent of male and 2.5 per cent of female therapists.

The true meaning of these figures is open to interpretation. The figures reported by the surveys cited must be regarded as representing a minimum estimate of the prevalence of client sexual abuse by therapists, at the time when they were carried out: there are many factors that would lead respondents to conceal or under-report their involvement. In addition, it is hard to know the extent to which these results are relevant to current-day practice, as there now exists a fairly comprehensive appreciation, by both clients and clinicians, of the destructive and exploitative nature of client–therapist sexual intimacy.

Historically, therapist sexual boundary violation has functioned as a ‘moral panic button’ that has been used to justify formal and distanced modes of client–therapist relating. Nevertheless, the erotic and sexual dimensions of the therapeutic relationship do represent a highly significant ethical and moral challenge for therapists. Within the emotional intimacy and privacy of the therapy room, it is not unusual for clients and therapists to experience sexual attraction. It would seem sensible to view this process as an inevitable consequence of sexuality as an essential aspect of being human. There is evidence that many therapists find these situations hard to manage (Martin et al. 2011; Rodgers 2011). Edelwich and Brodsky (1991) adopt a position of encouraging practitioners to view feelings for clients as normal: difficulties arise not because therapists have these feelings, but because they act on them inappropriately.

The harm that therapist sexual exploitation does to clients has been documented in a number of studies (Bates and Brodsky 1989; Chesler 1972; Durre 1980; Holtzman 1984; Nachmani and Somer 2007; Somer and Nachmani 2005). The process of therapy may include phases when the client is emotionally dependent on their therapist, and views sexual attention as a sign of being special. Within the confidential, private environment of the client–therapist relationship, it is possible for the therapist to sexually ‘groom’ their client with little likelihood of being found out. The focus of counselling on the personality and inner life of the client may readily result in the client blaming themselves and their own inadequacies for what has happened. Some clients believe that they are engaging in an authentic, romantic or love relationship with their therapist. These factors, taken together, make it possible to understand how sex between therapists and clients can occur, why it is under-reported, and why recovery may take a long time. Clients who have been sexually abused by professionals encounter great difficulty in achieving redress, because of the difficulty in providing verifiable evidence of what has happened to them.

Edelwich and Brodsky (1991) suggest the following therapist strategies for dealing ethically with feelings of attraction to clients:

- Acknowledge your own feelings.
- Separate your personal feelings from your dealings with the client.
- Avoid over-identifying – the client’s problems are not your own.
- Do not give your problems to the client.

- Talk to someone else about what is happening (e.g. colleagues or supervisor).
- Set limits while giving the client a safe space for self-expression.
- Do not be rejecting.
- Express non-sexual caring.
- Avoid giving 'double messages'.

They also point out that most sexual misconduct begins with other 'boundary violations', such as touching the client, seeing them socially, or inappropriate therapist self-disclosure to the client, and recommend that these apparently less significant boundaries be treated with great respect.

While it clearly represents a serious issue at the level of professional ethics, sexual boundary violation in therapy can also be understood from the perspective of relational ethics. Most client-therapist sexual behaviour takes place between male therapists and female clients, and the professional organisations that make it difficult for women to bring perpetrators to justice are dominated by men. Rutter (1989) has argued that sex between professional men (not just psychotherapists and therapists, but also clergy, teachers, doctors, and managers) and women over whom they are in a position of power or authority results from deeply held cultural myths about what it means to be male or female. Many men suppress and deny their own emotional pain and vulnerability, but hold on to a fantasy that they can be made whole through fusion with an understanding and accepting woman. The experience of sex with a woman client is, therefore, part of an unconscious search for healing and wholeness. It is, of course, only a temporary means of resolving this male dilemma, and soon the sexual intimacy will seem false and the woman will be rejected.

This interpretation of the dynamics of therapist sexual behaviour is consistent with the findings of a study by Holtzman (1984), who interviewed women who had been sexually involved with their therapists. Several of these women spoke of taking care of the therapist, of being aware of gratifying his emotional needs. Searles (1975) has described this process as the client unconsciously acting as therapist to the therapist.

According to Rutter (1989), women bring to this situation a lifetime of assaults to their self-esteem, of being told they are not good enough, particularly by their fathers. The experience of being in a working relationship with a powerful man who appreciates their abilities and qualities, and seeks to help them achieve fulfilment is, for the woman, a potentially healing encounter. The betrayal of this closeness and hope brought about by sexual exploitation is, therefore, deeply damaging. Chesler (1972) interviewed ten women who had had sexual relationships with their therapists. All were described as being insecure, with low self-regard, and all blamed themselves for what had happened. Mann (1989) and Pope and Bouhoutsos (1986) suggest that women at particularly high risk of sexual exploitation by a therapist have previously survived incest or sexual abuse in earlier life.

Some research has addressed the experiences of therapists who have been professionally disciplined following sexual contact with clients. Pilgrim and Guinan (1999) examined the cases of ten British mental health professionals (nurses, psychiatrists, psychologists, and hypnotherapists) who had been found guilty by their professional associations of sexual misconduct. The majority of these professionals had committed multiple abuse, were senior members of their organisations, and had elected to work with vulnerable groups of patients. Pilgrim and Guinan suggest that the profile of these mental health professionals was similar to that of sex offenders. However, Pilgrim and Guinan found that the relevant professional associations dealt with these cases in a very tolerant manner, allowing some of the therapists to continue practising. McNulty et al. (2013) interviewed three therapists who had been professionally disciplined. They found that neutralising the clients' 'patient-ness' represented a key stage in the process of entering a sexual relationship with a client – these therapists downplayed the needs of their clients and focused instead on their normalness. These therapists also regarded themselves as hero-figures, who were acting in a way that was beneficial for their clients, and described themselves as hurt and shocked when the client made a complaint about them.

In conclusion, therapist–client sexual contact cannot be regarded as merely a professional issue, to be contained and addressed within the boundary of training programmes and professional associations. Instead, it arises from fundamental fault-lines around gender relationships and sexuality in Western culture, linked to a broader moral agenda around such issues as sexual violence, trafficking, pornography, and sexual harassment at work.

### *Ethical issues involved in the use of touch*

The main underlying fear in relation to touch appears to be that touching will lead to sexual gratification on the part of the client, the therapist, or both. Another ethical concern is that the client may feel violated, and accept being touched against their wishes. For example, a person who has been physically or sexually abused may have a great terror of being touched, but may have little or no capacity to assert their own needs. Other people may have cultural or religious prohibitions in relation to being touched by a stranger, or by a member of the opposite sex.

An additional concern, for some therapists, arises from anxiety about being accused by clients of being over-intimate or exploitative. This can result in the adoption of a defensive policy of never offering a gesture of comfort or physical contact. In contrast to all of these concerns about the use of touch, it also needs to be acknowledged that touching is a basic expression of human caring and compassion, and that the unwillingness of their therapist to hold or hug them, or even to shake hands, can be experienced by the client as cold and distancing. It is clear, therefore, there are a number of legitimate ethical issues associated with the use of touch.

In relation to the ethics of touch in therapy, Hunter and Struve (1998) provide a wise pathway through these dilemmas, based on an analysis of the physiology and meaning of touching in human beings and the history of touch in therapy. They make a number of recommendations, stating that touch is clinically appropriate when:

- the client wants to touch or be touched;
- the purpose of touch is clear;
- the touch is clearly intended for the client's benefit;
- the client understands concepts of empowerment and has demonstrated an ability to use these concepts in therapy;
- the therapist has a solid knowledge base about the clinical impact of using touch;
- the boundaries governing the use of touch are clearly understood by both client and therapist;
- enough time remains in the therapy session to process the touch interaction;
- the therapist–client relationship has developed sufficiently;
- touch can be offered to all types of clients;
- consultation/supervision is available and used;
- the therapist is comfortable with the touch.

In contrast, it is clinically advisable *not* to use touch when:

- the focus of therapy involves sexual content prior to touch;
- there is a risk of violence;
- the touch occurs in secret;
- the therapist doubts the client's ability to say no;
- the therapist has been manipulated or coerced into the touch;
- the use of touch is clinically inappropriate;
- the touch is used to replace verbal therapy;
- the client does not want to touch or be touched;
- the therapist is not comfortable using touch.

These guidelines provide a useful framework for evaluating the use of touch in counselling and psychotherapy. It is clear, however, that much depends on the integrity of the therapist, and on the extent to which they have explored the meaning of touch for them personally.

## Ethical issues in research on therapy

Increasingly, therapists and therapy agencies carry out research into the processes and outcomes of therapy, as a means of enhancing the effectiveness of practice and in response to the expectation that all practice will be accountable. Research training always includes a strong emphasis on ethics, and professional bodies such as the BACP and the APA have published ethical guidelines specifically oriented towards the kinds of issues that can arise in the field of counselling and psychotherapy research. Some of the ethical dilemmas that can arise include the following:

- A client agrees to participate in research because they are concerned that lack of cooperation would jeopardise their therapy.
- A client completes a research questionnaire, and uses it to convey information that has not been disclosed to the therapist (e.g. suicidal thoughts) – can the client be confident that the therapist will receive the information?
- Completing questionnaires before and after every session can have a negative impact on the therapy process, by interfering with the normal therapeutic process; *or* completing questionnaires can have a positive impact, by giving the client an opportunity to reflect on important issues and monitor progress towards their goals.
- A client reads a book written by a therapist they saw a few years ago, and recognises himself in one of the case descriptions.
- A client agrees to take part in a study of therapy, then finds herself randomised into a control group that will not receive therapy until after a six-month waiting period.
- A research study involves recordings being made of therapy sessions – a client agrees to this but nevertheless remains cautious about what he says to his therapist.
- A therapist gains the assent of a client to allow recordings of their work to be used in a case study – the therapist is particularly interested in the role of dreams in therapy, and consistently encourages their client to recall dream material.

As in other areas of ethical good practice, the resolution of these ethical dilemmas involves the application of principles and procedures around informed consent, confidentiality, and avoidance of harm. However, research data collection and analysis, and eventual publication of results, introduces an additional dimension of ethical complexity into a situation in which people may be emotionally vulnerable and open to manipulation. Ethical issues in counselling and psychotherapy research are discussed in more detail in McLeod (2010, 2013a).

## Strategies for maintaining ethical standards

Increasing attention has been devoted by professional organisations in recent years to the question of how to maintain and enforce ethical standards. To some extent, these efforts have been motivated, particularly in the USA but also in other countries, by the recognition that media coverage of cases of misconduct was reducing public confidence and leading government agencies to impose legal penalties, thereby reducing professional autonomy. All professional organisations require their accredited members to abide by a formal code of ethics, and all enforce procedures for disciplining members who violate these codes. Increasingly, however, in some countries, aspects of the enforcement of therapy standards are being taken over by the courts (Wexler 1990). Further strategies for maintaining ethical standards include initiatives around innovative approaches to training

in ethical issues (Bashe et al. 2007) and the use of supervision as a means of managing therapists who have transgressed ethical guidelines (Kress et al. 2015).

## Legal considerations

Several areas of therapy practice are covered by legal statutes that may be enforced through the courts and criminal justice system. These include many aspects of confidentiality, including: data protection rules regarding electronic information; requirements around disclosing information to the courts; the duty to protect and warn; and record-keeping. In many jurisdictions there are also legal requirements around qualifications to practice, professional negligence, advertising/marketing, and use of titles. There are laws that cover circumstances in which individuals are subjected to enforced treatment or hospitalisation, and the rights of children and vulnerable groups. The growth of counselling and psychotherapy on-line has resulted in laws that control this practice, for instance in relation to therapist qualifications being recognised in the country or state in which the client resides. Legislation that refers to the practice of counselling and psychotherapy is different in different countries, and it is essential for practitioners to be familiar with the specific situation that pertains within the country or state within which they work. Legislation is routinely revised and changed by law-making bodies. All therapy professional associations publish up-to-date information about legal aspects of practice, and offer advice to members around particular scenarios and dilemmas. The key source of information for therapists practising in the UK is *Professional Practice in Counselling and Psychotherapy: Ethics and the Law* (Jenkins 2017). In addition, most therapists are covered by professional indemnity insurance, either through their own subscription or through the organisation that employs them. Insurance providers not only offer cover for the costs of legal action, but in many cases will offer advice.

## Cultural differences in ethical values and perspectives

There are significant cultural differences in relation to ethical values and decision-making. For example, in recent years, the expansion of counselling and psychotherapy in India and China has resulted in a number of studies of contrasting ethical perspectives between these mainly collectivist countries and the USA (which is strongly individualist) (Bhola and Chaturvedi 2017; Sinha et al. 2017; Zhao et al. 2011; Zheng et al. 2014). In India, for instance, procedures around informed consent and confidentiality usually involve key family members, rather than being negotiated solely between the client and therapist. The implication of these cultural factors is that it is vital that therapists do not make assumptions about what will be viewed as 'right' or 'appropriate' around boundary arrangements in therapy, and other ethical issues, but should remain open and curious about potential cross-cultural points of divergence.

## Conclusions

Ethical therapy means more effective therapy: people are more likely to be more open and honest about what they say about themselves if they trust that their personal information will be heard in confidence. The aim of the present chapter has been to offer an introduction to a range of perspectives and sources of knowledge that may be relevant when making ethical decisions. A key emphasis within the chapter has been on viewing this aspect of practice in terms of the construction of an ethical space within which consultation and reflection can take place, rather than as a matter of using pre-set rules to arrive at a binary, right/wrong judgement. The discussion in this chapter of moral, ethical, and value dimensions of therapy needs to be read in the context of all the other chapters in the book: moral issues are integral to all aspects of therapy.



## Topics for reflection and discussion

- 1 What kind of information and support is available for clients and service users, regarding boundary violations and other types of ethical misconduct committed by therapists? Compare on-line information provided by any three professional therapy associations. How adequate is the information that they provide? How could it be improved?
- 2 In which circumstances in therapy might your values be in conflict with those held by a client? Or, in which circumstances in therapy might your values be in conflict with those held by the therapist? What might you do in such circumstances? What impact might such a values issue have on the progress of therapy?
- 3 As a client, what power do you have in therapy? For example: 'I have the power to decide whether I want to talk about a particular issue, to decide not to return', etc. As a therapist, what power do you have? What does client abuse of power look like? What does therapist abuse of power look like?
- 4 This chapter includes several examples of research into ethical issues – case study research as well as surveys and interviews with clients and therapists. What further research do you think would be useful, as a means of advancing our understanding of ethical issues in therapy?
- 5 Austin et al. (2005) describe 'moral distress' as a reaction to a situation in which you believe you know the right thing to do but don't do it. You know that you have some moral responsibility, but do not act on it. Identify one therapy-related incident where you have experienced moral distress. What was it like and what did you learn from what happened?

## Suggested further reading

The topics introduced in this chapter are explored in detail in Bond (2015) and Pope and Vasquez (2016). *Red Flags in Psychotherapy: stories of Ethics Complaints and Resolutions* by Patricia Keith-Spiegel (2013) vividly describes how an ethics board responds to typical complaints. The work of Alan Tjeltveit (2000, 2004) and Alan Lerner (2011, 2015a, 2015b) is invaluable for anyone interested in an awareness of moral and ethical issues that goes beyond ethical codes. The journal *Ethics and Behaviour* publishes research papers and review articles on a range of ethical issues in therapy. *Issues in Counselling and Psychotherapy Practice: Walking the Line* (Bhola and Raguram 2016) includes cutting-edge discussion of ethical issues that occur in a range of different areas of therapy practice.



# Chapter 30

## Using research to inform practice

<b>Introduction</b>	<b>471</b>
<b>The historical development of research into counselling and psychotherapy</b>	<b>472</b>
The importance of methodological pluralism	474
<b>Research into the outcomes of therapy</b>	<b>474</b>
Client satisfaction studies	474
Randomised clinical/controlled trials	475
Practice-based outcome studies	478
Therapy drop-out rates	479
Behaviour change	480
Cost-effectiveness	480
Qualitative outcome research	480
Outcome-oriented case studies	481
Surveys	481
Structural change	482
Action research	483
Outcome research: reflection and conclusions	483
<b>Research into the process of therapy</b>	<b>484</b>
Studies of process from a client-centred perspective	484
Studies of process from a psychodynamic perspective	486
The 'events paradigm'	486
The process as experienced by the client: qualitative research	487
Case studies	489
<b>Professional knowledge studies</b>	<b>491</b>
<b>First-person research</b>	<b>491</b>
<b>Ethical issues in therapy research</b>	<b>491</b>
<b>The relevance of research for practitioners</b>	<b>492</b>

<b>The relevance of research for clients</b>	<b>492</b>
<b>Conclusions</b>	<b>492</b>
<b>Topics for reflection and discussion</b>	<b>493</b>
<b>Suggested further reading</b>	<b>494</b>

## Introduction

Increasingly, ethical professional practice in counselling and psychotherapy requires being research-informed. Research into counselling and psychotherapy refers to the application of scientific methods to answer questions such as ‘is therapy effective?’, ‘what are the processes and activities that lead to either positive or negative outcomes for clients?’, and ‘are some therapists more effective than others and, if so, why?’ A scientific perspective on therapy is not uncontroversial. There are good reasons to view therapy as an art or a craft that gradually evolves in response to the ingenuity and creativity of practitioners, the demands of service users, and shifting currents of cultural life. There are also good reasons to be concerned that scientific generalisations derived from analysis of large data sets has a risk of leading to top-down governmental or institutional imposition of certain types of therapy rather than others – thus reducing flexibility and diversity of provision. In taking account of these critical perspectives, therapy researchers have been forced to develop an approach to scientific inquiry that is characterised by methodological pluralism – an appreciation that counselling and psychotherapy are complex, multifaceted, and contextualised, and can only be understood through the application of as wide a range of research techniques as possible.

Good research ultimately facilitates the development of a better understanding of events and processes that are experienced by therapists and clients, in ways that enable practitioners to learn from each other and their clients to be more productively invested in the work of therapy. Research promotes a critical and questioning attitude, one that helps therapists and therapy service managers to improve the quality of service offered to clients. Research allows the voice of clients and service users to be heard, and to influence the ways in which therapy is organised and delivered. Research is an international activity, with research journals being read by a worldwide audience: participation in such an international community of scholars helps therapists to achieve a broader perspective on their work.

The field of therapy research comprises a wide range of topics and questions, which can be divided into four broad areas:

- 1 Outcome research:** research into the effectiveness of therapy and its benefits to clients and society.
- 2 Process research:** identifying the ingredients of therapy that contribute to outcome and developing models of how change occurs and how it can be facilitated.
- 3 Therapist effects:** studies of the qualities and attributes of therapists, and ways of enhancing therapist competence such as training and supervision.
- 4 Professional knowledge:** documenting and disseminating what therapists have learned about how to work most effectively with different client groups and using different therapy approaches.

There are also many reasons for doing research. Factors that motivate people to conduct research in the field of therapy include:

- testing the validity of theory or refining and developing theory;
- evaluating the effectiveness of different therapy approaches or techniques;

- demonstrating the cost-effectiveness of counselling or psychotherapy to a third-party funding agency (e.g. government department, insurance company, private company);
- quality improvement – enabling a clinic or agency to develop better services for clients;
- learning about how to adapt therapy to meet the needs of different client groups;
- enabling clients to influence the development and provision of services;
- adapting therapy practice to take account of new advances in technology;
- enabling an individual practitioner to monitor and reflect on their work;
- intellectual curiosity – allowing individual practitioners or researchers to explore and resolve ‘burning questions’;
- fulfilling personal or occupational aspirations by getting a Master’s degree or PhD;
- letting colleagues know about particularly interesting cases or innovations;
- establishing the academic credibility of counselling and psychotherapy as a subject taught in universities;
- enhancing the professional status of counsellors and psychotherapists in relation to other professional groups.

It can be seen that therapy research is wide-ranging – there are many different questions that can be pursued, and different reasons for doing research. Although each therapist or service user will likely be able to identify particular research topics that are most relevant for them, a balanced appreciation of research evidence around these topics requires a critical appreciation of the research literature as a whole.

The present chapter offers a map of the landscape of contemporary research in counselling and psychotherapy. The aim is to provide both clients and therapists with an appreciation of what is known, what is not known, and what is possible in relation to the role of science in psychotherapy. The chapter is written from an underlying position that maximising the positive potential of scientific inquiry in this field, and minimising its negative potential for authoritarian control, requires as many people as possible to engage in dialogue and decision-making around the kind of science that is carried out, the kinds of topics that should be investigated, and judicious appraisal of the difficult challenge of knowing how best to apply scientific findings in relation to practice.

## **The historical development of research into counselling and psychotherapy**

To make sense of the counselling and psychotherapy research literature, in terms of the questions and issues that have been pursued or neglected, and the research methodologies that have been applied to these questions, it is necessary to adopt a historical perspective. Although some interview and questionnaire studies into the effectiveness of psychoanalysis had been conducted in the 1930s and 1940s, a systematic programme of therapy research only became possible following the pioneering work of Carl Rogers and his colleagues in the 1940s. This group showed how it is possible to apply techniques that had been developed in mainstream psychology – such as questionnaire measures of adjustment and direct observation of interaction through audio recording – to the field of counselling and psychotherapy. In addition, they led the way in showing how research could be used to build a new theory of therapy (client-centred therapy) and to inform training and practice. The team fronted by Rogers focused on two key questions that have continued to dominate therapy research: (1) is therapy effective? and (2) what are the processes that contribute to effectiveness?

This kind of research, motivated by intellectual curiosity and an openness to new ideas, was pursued by leading figures such as Carl Rogers, Hans Strupp, and Klaus Grawe up until the 1980s.

From the mid-1980s, important changes in both the external social environment in which therapy operated, and in the internal landscape of counselling and psychotherapy itself, brought about a significant shift in the aims and direction of therapy research. Externally, European and North American society began to move away from an expansionist and inclusive social welfare ethos, in the direction of a more competitive neoliberal political philosophy. Within the world of therapy, the expansion and success of cognitive behavioural therapy (CBT) was driven by key figures such as Eysenck, Rachman, and Wolpe, who genuinely believed that their approach to therapy was substantially more effective and scientifically grounded than earlier models of therapy such as psychodynamic and client-centred. As a result of these forces, therapy research went through a period in which randomised clinical (or controlled) trials (RCTs) were increasingly used to compare the effectiveness of different models of therapy. Such studies were expensive to carry out and rapidly soaked up most of the financial resources available for therapy research. In turn, the findings of such studies were increasingly used to define the types of therapy that could be offered in health-care systems. At a technical or methodological level, the drive to conduct rigorous RCTs fuelled an expansion in work around accurate measurement of outcomes, and sophisticated techniques for statistical analysis of large data sets. At a conceptual level, this type of research brought about a rapprochement with psychiatry, through the use of diagnostic categories to define clients for inclusion in controlled studies.

While all this was happening, there was considerable resistance from both frontline therapists and some academic researchers, who questioned the relevance of RCT evidence for everyday clinical practice and were horrified by the prospect of ending up with a sterile therapy mono-culture in which clients were restricted to a choice of only one or two ‘empirically validated’ approaches to therapy. Over the last 20 years, this resistance has had the effect of energising researchers to develop a range of alternative methodologies: brief measures for evaluating outcomes in routine practice; qualitative research; autoethnographic studies; systematic case-based inquiry; and research using methods from neuroscience. Some researchers and service user groups have gone further in questioning the power dynamics of conventional research (‘who is this knowledge for?’) and devising forms of collaborative and participatory action research.

A further, unexpected, development within the historical evolution of research in counselling and psychotherapy has been the discovery that, for most practical purposes, almost all plausible forms of therapy produce equivalent results for most presenting problems. In other words, the underlying premise of RCT-based research, that it would be possible to grind through all possible comparisons between different therapy approaches and find a clear-cut ‘winner’, has been shown to be unfounded (Wampold and Imel 2015). It turns out that the model of therapy being applied is not a particularly strong predictor of eventual client outcome. At the time of writing, the leading contenders for factors that make a difference to outcome are client preferences, therapist personal qualities, and client–therapist ‘fit’ (i.e. capacity to establish a collaborative relationship).

What does all this mean for therapists, service users, and researchers now? One important implication is that there exists a very wide array of ways of doing research. Even if quantitative studies still comprise the largest single group of published research articles each year, there is a growing body of research that makes use of qualitative and other approaches. A further important implication is that the majority of concepts and ideas in therapy have been investigated by someone, somewhere. Thus, the objections of many clients and therapists, that research cannot be carried out into hard-to-observe phenomena such as unconscious processes, spiritual experiences, or the effectiveness of clinical supervision, are no longer credible. Although there have been relatively few studies of such phenomena, compared with studies of therapy outcome, an evidence base does exist, with the consequence that it becomes possible to use research findings, alongside personal experience and theory, to inform practice in such areas. A final, somewhat uncomfortable, aspect of the current situation as regards therapy research is that it is in a state of transition. A broadly medical model approach to research has been shown to have limited applicability to enhancing the quality of therapy. However, such an approach continues to carry legitimacy in the eyes of policy-makers and

funding agencies, and the practical yield of alternative methodologies has yet to be convincingly demonstrated. As a result, as regards the links between research and practice in therapy, we are currently at a stage of great potential but considerable uncertainty.

## The importance of methodological pluralism

As the story of therapy research has unfolded, it has gradually become clear that one of the main challenges for researchers lies in the complexity of what happens in therapy. The moment-by-moment interaction between a client and therapist takes place at many levels: events in the brain and nervous system, language, non-verbal actions and gestures, emotions, memories, cultural beliefs, and values. All of this is influenced by (and influences) events in the everyday life of both the client and therapist. These processes occur over and over again, sometimes for years, with the possibility that the same words or actions may take on different meanings at different times. One of the hardest lessons for the therapy research community has been to acknowledge the significance of the complex nature of the phenomena and processes that are being investigated. This acknowledgement is reflected in a growing willingness to embrace the principle of *methodological pluralism* (Slife and Gantt 1999; Slife et al. 2005). The assumption behind methodological pluralism is that because therapy is complex and hard to understand, researchers need to make use of all the methodological strategies that are available: measures, controlled comparative studies, qualitative interviews, micro-analysis of language use, personal experience research, case studies, and anything else that might seem relevant.

## Research into the outcomes of therapy

Outcome and evaluation studies have the primary aim of finding out how much a particular counselling or therapy intervention has helped or benefited the client. Investigations that document the outcomes of therapy in routine situations are usually described as *effectiveness* studies. Analysis of outcome in more tightly controlled conditions, with narrowly defined groups of clients, and comparisons between alternative treatments, are usually described as *efficacy* studies. Estimates of the efficacy of a treatment indicate how well that approach does in ideal circumstances. By contrast, effectiveness reflects how well it does in the messy world of everyday practice.

The investigation of therapy outcome is a highly sensitive, politically charged area of inquiry. People with problems obviously want to know how likely it is that therapy will help them. Therapists want the reassurance of knowing that the type of therapy they practise is at least as effective as (and hopefully more effective than) competing approaches. Healthcare organisations and other agencies that fund or sponsor counselling and psychotherapy services want to know whether they are getting value for money. All of these groups are interested in how therapy compares with other interventions such as medication or self-help.

It is not easy to estimate the effectiveness of therapy, either on an individual basis or across a sample of clients. There is an inevitable trade off, in terms of both cost/time and interference in the normal process of therapy, between keeping it simple (e.g. focusing solely on whether a person gets less depressed or anxious) and taking a more holistic approach that takes account of all aspects of a person's life. The following sections provide an introduction to the main strategies that have been used to investigate therapy outcome. While none of these approaches is capable of yielding a perfect assessment of outcome, each of them has something valuable to offer.

## Client satisfaction studies

The most straightforward way to collect information about the outcome of therapy is to ask the client, at the end of therapy, to complete a satisfaction rating scale. Typically, such scales include broad questions such as overall satisfaction with therapy, alongside more specific questions around factors such as satisfaction with waiting times, privacy in rooms, choice of therapist, relationship with

therapist, and so on. Ratings are usually on a 5-point scale, rather than 'yes/no', to capture gradations in satisfaction. The form may also include a space for open-ended comments. The advantages of client satisfaction questionnaires are that they give clients a voice, provide a readily available channel to pick up client dissatisfaction or possible ethical breaches, are flexible (specific questions can be added to reflect areas of relevance to the organisation), inexpensive to print and distribute, and easy to analyse.

However, there are three major limitations of this approach. First, it depends on the client having an agreed ending at which they are given the form, and then being willing to complete the form. This is problematic because many clients drop out of therapy or may forget to return the form. It is likely that those who drop out or fail to fill in the form are less satisfied clients. In contrast, those who stay the course or are happy to take time to complete a form tend to have had a better therapy experience. The second difficulty is that the ratings made by clients in such a situation may be influenced by a 'halo effect' of being grateful to their therapist (as someone who listened carefully to them and was genuinely interested in their well-being), rather than reflecting an objective self-appraisal of whether they have in fact changed as a result of therapy. Third, the form only provides a picture of how the person felt at that particular point in time, rather than showing whether therapy had an enduring effect. Taken together, these factors mean that, compared with other methods for evaluating outcome, client satisfaction measures produce much higher rates of perceived benefit of therapy, with around 90–95 per cent of completed forms indicating high levels of satisfaction. The consensus within the therapy research community is that while it is always valuable to collect client satisfaction ratings, it is sensible to supplement this kind of information with the use of other evaluation techniques. Further discussion of counselling and psychotherapy satisfaction rating techniques can be found in Oei and Shuttlewood (1999).

## Randomised clinical/controlled trials

In the 1930s, 1940s, and 1950s, several studies into the effects of psychoanalysis used follow-up questionnaires to find out what had happened to former patients (see, for example, Schjelderup 1955). The results of these investigations suggested that, overall, around two-thirds of the psychoanalytic patients followed up improved, with one-third remaining the same or experiencing a deterioration after treatment.

These findings appeared highly encouraging for psychoanalysis and, by implication, for other forms of counselling and psychotherapy. However, in 1952, the British psychologist Hans Eysenck published a devastating critique of this early research. Eysenck pointed out that studies of neurotic people who had not received therapy but had been followed up over a period of time also produced an improvement rate of around 60 per cent. He argued that psychoanalysis could not be considered effective if it produced the same amount of benefit as no therapy at all. Eysenck suggested that there existed a process of 'spontaneous remission', by which psychological problems gradually became less severe over time owing to non-professional sources of help in the community or because the person had learned to deal with a crisis situation that had provoked a breakdown.

The psychotherapy world reacted strongly to Eysenck's critique: the main effect of his attack was to force researchers to design more adequate studies. In particular, it became accepted that outcome studies should include a control group of clients who do not receive treatment, so that the impact of the counselling or therapy can be compared with the improvement brought about by spontaneous remission. One method of creating a comparison group of this kind has been to use a 'waiting list' group of clients who have applied for therapy but who are not offered their first appointment for some time, and are assessed at the beginning and end of that period to detect any changes that might have occurred in the absence of professional help. Another strategy is to randomly allocate clients to different treatments or to a placebo condition (e.g. regular meetings but no active therapy). Research designs that involve random allocation to different conditions are known as randomised controlled trials (RCTs). A major advantage of an RCT design is that, if proper randomisation has taken place, then any differences in outcome across conditions must have been caused by the intervention – any other causal factors have been controlled through randomisation.



One of the first outcome studies to use an RCT design was a comparison of the effectiveness of psychodynamic therapy with a behavioural approach (Sloane et al. 1975). The study was carried out in a university psychiatric outpatient clinic, and applicants for therapy were screened to exclude those too disturbed to benefit or who required other forms of help. Ninety-four clients were randomly allocated to behaviour therapy, psychodynamic therapy, or a waiting list group. The people on the waiting list were promised therapy in four months, and were regularly contacted by telephone. Clients paid for therapy on a sliding scale and received, on average, 14 sessions over four months. Before the beginning of therapy, each client was interviewed and administered a battery of tests. In addition, clients identified three target symptoms and rated the current intensity of each of those symptoms. Ratings of the level of adjustment were also made by the interviewer and a friend or relative of the client. These measures were repeated at the end of the therapy, and again at one-year and two-year follow-up. Every fifth session was audio-recorded and rated on process measures of therapist qualities, such as empathy, congruence, and acceptance. The speech patterns of therapists and clients were also analysed from these tapes.

The results of Sloane and colleagues' (1975) study indicated that, overall, more than 80 per cent of clients improved or recovered at the end of therapy, with these gains being maintained at follow-up (these outcomes are somewhat more positive than those reported in more recent studies). Both treatment groups improved more than the waiting list group. The quality of the therapist–client relationship was strongly associated with outcome, for both types of therapy (a result that has been strongly confirmed in many subsequent studies).

Over the past 40 years, several hundred therapy RCTs have been carried out along similar lines to that of Sloane et al. (1975); most have arrived at similar conclusions regarding equivalence in the relative effectiveness of different approaches.

It is important to appreciate both the advantages and disadvantages of RCTs as a means of investigating therapy outcomes. RCTs are considered highly credible – they are generally viewed as objective and unbiased, and have been widely used to produce advances in medicine and healthcare. On the other hand, RCTs are difficult to organise and expensive to implement, and as a result have tended to be carried out in elite therapy institutions, such as university psychiatry or psychology clinics. The therapists in these studies conduct therapy in accordance with 'treatment manuals' that tightly define how they should work with their clients. Clients in such studies are selected on the basis of a single diagnostic category (e.g. depression, panic disorder). All these factors mean that RCTs of the efficacy of therapy (i.e. how well it does under ideal circumstances) can be criticised as unrepresentative of everyday practice (Morrison et al. 2003; Westen et al. 2004). There has been considerable debate within the counselling and psychotherapy professional community about the pros and cons of RCTs in relation to providing evidence of the relative efficacy of different forms of therapy. However, despite widespread misgivings about this approach, RCTs remain the evidence source of choice for governmental and health service policy-makers.

### Box 30.1: The development of symptom measures

The proliferation of therapy outcome research that has taken place since the 1950s would not have been possible without the development of brief self-report measures of depression, anxiety, and other symptoms that could be completed by clients/patients. The earliest outcome research had sought to measure variables such as self-concept and personality structure, using time-consuming techniques such as the Q-sort and projective techniques. By contrast, symptom measures such as the Symptom Checklist 90 (SCL-90), Hospital Anxiety and Depression Scale (HADS), and the Beck Depression Inventory (BDI) were easy to administer, and collected information on change in relation to diagnostic categories that were not limited to any specific theory of therapy. One of the persistent

dilemmas in the field of therapy outcome research centres on the question of how satisfactory these measure are in assessing real-world change (Kazdin 2006), and what is actually happening when someone completes such a scale (Blount et al. 2002; Galasiński 2008; McLeod 2001).

### Box 30.2: Meta-analysis

As the results of more and more therapy RCTs were published, it became necessary to find some means of determining whether an overall pattern had emerged regarding the relative effectiveness of different therapies for different problems. Meta-analysis is a statistical technique that involves calculating the average amount of client change reported for each approach in each separate study (the effect size, ES), then adding up these change scores to produce an average ES of how much benefit a particular approach (such as psychoanalysis, client-centred therapy, or behaviour therapy) yields over a set of studies comprising a large number of clients. An ES of more than 0.8 would indicate that about 60 per cent of clients had significantly gained over the course of therapy. The first psychotherapy meta-analysis was published by Smith et al. (1980). Over time, meta-analytic procedures have become more and more sophisticated, and have been widely applied in an attempt to answer the question of whether some therapy approaches are more effective than others.

### Box 30.3: The researcher's own therapeutic allegiance – a factor in outcome research

The concept of the 'experimenter effect' is familiar to anyone who has studied psychology. In a psychology experiment carried out in a laboratory, the expectations of the researcher in relation to what they believe the experiment will show can be subtly communicated to subjects, and influence their responses to stimuli or tasks (Rosnow and Rosenthal 1997). The impact of 'experimenter effects' is to skew results so that the experimenter's hypothesis will be confirmed. Does the experimenter effect apply in psychotherapy outcome studies? It seems unlikely that it would, because therapy is a 'real-world' situation and clients have strong motivation to get what they need from therapy, rather than trying to 'second-guess' the expectations of the person or team running the study.

Luborsky et al. (1999) wished to find out the extent to which researchers' expectations and biases might be operating in psychotherapy outcome research. They reviewed 29 studies in which the relative effectiveness of two forms of therapy was compared. They then carried out a painstaking analysis of what was known about the therapeutic allegiances of the researchers who conducted the studies. They found a significant positive relationship between allegiance and outcome. For example, in a study carried out by a psychodynamic researcher, comparing cognitive-behavioural and psychodynamic therapy, it would be virtually certain that the results would favour the psychodynamic approach. In a study carried out by a researcher positively oriented towards cognitive-behavioural approaches, CBT would be likely to emerge as the most effective therapy. Luborsky et al. (1999) argued that researcher allegiances seriously distort, and call into question, the findings of outcome studies, and made a number of suggestions for eliminating this source of bias. However, despite 20 years of awareness of this issue, it is still possible to detect research allegiance effects in therapy RCTs (Dragioti et al. 2015; McLeod 2016; Munder et al. 2011, 2013).

## Practice-based outcome studies

Dissatisfaction with an over-reliance on RCT methodology in studies of the outcomes of therapy has motivated researchers to test alternative approaches to investigating this question. The main strategy that has emerged has been *practice-based* research (Barkham et al. 2010) whereby data are gathered in routine everyday therapy practice rather than through specially designed research projects such as RCTs. Although in principle the concept of practice-based research (and practice-based evidence) refers to any data collected in routine clinical practice, it has been mainly implemented by asking clients to complete brief symptom measures at each therapy session. This approach has been made possible by the development of short, accessible self-report scales such as CORE, OQ, TOPS, PHQ, and GAD (for further information on these measures, see McLeod 2013a).

While introducing a greater degree of ecological validity to outcome research, as with RCTs, naturalistic practice-based outcome studies are associated with a number of methodological limitations. Typically, organisations that ask clients to complete outcome measures usually find that about 95 per cent of clients do so at the start of therapy. However, many clients have unplanned endings. As a result, in studies that only collect measures from clients at the start and finish of therapy, end-of-therapy data may be available for as few as 60 per cent of clients. It is then hard to interpret what has happened to the missing 40 per cent. While some of them will be good outcome cases, who have stopped attending because they feel well, it is probable that a larger proportion will have quit because they feel worse or do not think that therapy has been helpful. Increasingly, this problem is being addressed by collecting data from clients at each visit, so that even if the client drops out, information about change in symptoms and well-being is available in the questionnaire that they completed at their final session.

An important aspect of the way in which practice-based outcome data are interpreted is estimation of reliable and clinically significant change. For most standard outcome measures, it is possible to estimate a cut-off point that differentiates between a 'normal' level of problems or symptoms and a more serious 'clinical' level. Clients who, over the course of therapy, move from the clinical to the normal range are designated as demonstrating clinically significant change. It is also possible to use statistical procedures to estimate the amount of change that could be interpreted as meaningful or 'reliable'. For example, a shift of one or two points on CORE would be likely to indicate random or situational fluctuation in mood or well-being, while a shift of five or more points would be more likely to reflect a real or reliable change. The publication of outcome results in terms of percentage of clients who reliably improve or clinically improve offers a form of reporting that is more accessible and meaningful to therapists and clients than the previous tendency to analyse outcomes solely in terms of changes in overall average scores across groups of clients.

These procedures for estimating clinical and reliable change can be applied to the analysis of deterioration or negative outcome, as well as to positive outcome. This has opened up new understandings of the degree to which people get worse over the course of therapy (an average of 8–10 per cent of clients).

Practice-based research has made a major contribution to democratising and opening up outcome research. It is relatively straightforward for therapy organisations to collect and analyse local outcome data and compare their results with benchmarks available from similar agencies. Practice-based data also provide a valuable platform for case study analysis and the use of scores for client feedback and tracking. Other initiatives have involved the accumulation and analysis of extremely large data sets, which make it possible to engage in data mining analyses (see, for example, Stiles et al. 2006, 2008). One of the important discoveries to emerge from analysis of such data sets has been the extent to which therapists differ in effectiveness (see Chapter 27).

At the same time, alongside these contributions, it is important to recognise that practice-based research is a somewhat blunt instrument. Few practice-based studies collect data beyond the final visit of the client. This is an important design weakness in such studies: positive outcomes can be interpreted as reflecting a supportive effect of having someone to talk to each week, rather than an indicator of lasting benefit. A further methodological problem in naturalistic studies concerns the

question of whether a brief self-report questionnaire is sufficiently comprehensive and sensitive to assess change in relation to the specific issue that troubles a client. These scales are well suited to documenting the severity of distress in someone who is generally anxious or depressed, and has an awareness of these factors. They are perhaps less accurate in relation to measuring severity of a problem in people whose difficulties are expressed in somatic, bodily complaints, or are highly specific or narrowly defined (i.e. not covered by any of the questions in the scale). For these reasons, a growing number of practice-based outcome studies have started to ask clients to complete personalised problem/goal rating forms on a weekly basis, alongside symptom measures such as CORE or OQ. A further limitation of practice-based research is that, typically, little is known about the therapy that is being delivered. This stands in contrast to RCTs and case study designs, where the model of therapy being used is specified or described in great detail.

### Box 30.4: The CORE outcome measure – an essential evaluation tool

There are significant difficulties faced by practitioners seeking to evaluate the outcomes of their own practice. A large number of different questionnaires have been used previously by researchers, and it can be hard to decide which is the most appropriate. In addition, many outcome scales are copyrighted by publishing companies, with the result that they may be expensive to purchase, or access to them may be restricted to people who have completed specific training courses. As a response to these barriers to research, the Mental Health Foundation in Britain commissioned a team at the Psychological Therapies Research Centre, University of Leeds, to produce a new outcome questionnaire that embodied 'best practice' from existing scales, and could be made widely available to practitioners and researchers.

The CORE (Clinical Outcomes Routine Evaluation) scale is a 34-item self-report questionnaire that measures client distress in terms of four dimensions: well-being, symptoms, functioning, and risk (Evans et al. 2000; Mellor-Clark 2006; Mellor-Clark and Barkham 2006b; Mellor-Clark et al. 1999). It can be copied without charge, and a low-cost software package is available to facilitate data analysis. The CORE questionnaire has been widely adopted by counselling, psychotherapy, and clinical psychology service providers. It forms part of a range of measures and information management tools developed by the CORE group, including brief versions and scales for young people, and has been translated into several languages. The CORE scale has been widely used to collect naturalistic data on the progress of therapy with clients in a range of settings, and to build up a data set and norms that enable 'benchmarking' of standards of effectiveness in different settings. Further information on the use of CORE is available on the CORE website (see [www.coreims.co.uk](http://www.coreims.co.uk)).

## Therapy drop-out rates

The percentage of clients who drop out of therapy early, or who have unplanned endings, can be used as an indicator of the effectiveness of therapy. While it is certainly the case that some clients drop out because they have got what they needed, the majority of those with unplanned endings are likely to be clients or service users who are dissatisfied with their therapy, and do not believe that it has helped them. In practice, it is hard to interpret the DNA ('did not attend') and unplanned ending rates reported in different studies or by different therapy agencies, because there is no standard set of criteria or procedures for defining various types of ending. Nevertheless, it is clear that a significant proportion of clients walk away from therapy before it has had a chance to help them. This is a waste of resource (i.e. unused therapy sessions) and drives up waiting times. It may also have a

detrimental effect on clients who quit therapy, if it leads them to be wary about seeking further professional help. There will also be a proportion of such clients who may have been harmed by therapy. (Research into DNA rates and other types of therapy ending is discussed in Chapter 6.)

## Behaviour change

From a behaviourist perspective, assessing outcome in terms of changes in scores on anxiety, depression, or other symptom measures is unsatisfactory, because it is hard to determine the meaning, in terms of real-life change, of scores on these scales (Kazdin 2006). An alternative strategy involves collecting information on actual changes in behaviour, such as attendance at school, frequency of panic attacks per day, or work performance. Many behaviourally oriented outcome studies use such metrics, often in combination with conventional symptom questionnaires. Such an approach is difficult to implement in respect of the evaluation of therapies that are not explicitly oriented towards behaviour change.

## Cost-effectiveness

The issue of outcome is closely connected to questions of cost. Counselling and psychotherapy, particularly long-term therapy, are costlier than most types of medication, and much more costly than self-help. Therapy is grounded in an ethical stance of client autonomy and choice. From that perspective, if a client wants, for whatever reason, to carry on attending therapy for years on end, it is up to them – outcome in terms of behaviour change or symptom change is not relevant. However, a great deal of therapy is provided by healthcare and other organisations that cannot afford to give the client a blank cheque. The question then arises of the comparative costs of different types of therapy for different presenting problems. For example, it is possible that a client who has experienced childhood trauma may significantly improve after a year of psychodynamic therapy. If, however, the same benefit can accrue from six months of CBT, there is a strong incentive for a therapy service to prioritise the latter approach. Another type of economic issue concerns the phenomenon of cost-offset or prevention. For example, it may be worth investing in frontline therapy provision, for example in community clinics or primary healthcare settings, if it can be shown that this kind of support means that the person is less likely, later in life, to develop serious problems that require expensive in-patient psychiatric treatment. The ambitious and wide-ranging government funded Improving Access to Psychological Therapies (IAPT) programme in England was based on a rationale that individuals who had mental health problems, and were in receipt of welfare or sickness benefits, could be helped by psychotherapy and counselling to re-enter the workplace and become productive taxpayers. Relatively few studies of the economic outcomes of therapy have been carried out owing to the technical difficulties in measuring all of the different types of costs that may be associated with therapy. Examples of such studies include Abbass et al. (2015), Altmann et al. (2016), Maljanen et al. (2016), and Mavranouzouli et al. (2015). On the whole, such studies have reported that psychotherapy is cost-effective compared to other forms of intervention for mental health difficulties.

## Qualitative outcome research

Randomised controlled trials and practice-based studies comprise the main research approaches that have been used to evaluate the effectiveness of therapy. In addition to these quantitative methodologies, evidence of therapy outcome can also be collected through qualitative follow-up interviews with clients (McLeod 2011, 2013b). Qualitative approaches play an important role in building a more complete understanding of the nature of therapy outcome. Qualitative interviews with clients after the end of therapy are time-consuming and expensive to conduct, and can only be used with relatively small samples of clients.

The relatively few such studies that have been published open up a different perspective on outcome. Interviews with clients suggest that they have their own distinct criteria for evaluating the effectiveness of therapy (Kuhnlein 1999; Valkonen et al. 2011). On the whole, clients do not think



about therapy in terms of symptom reduction, but in terms of whether it can help them to move on in their life. For some clients, 'moving on' means getting back to where they were before something bad occurred (e.g. a loss or trauma). For others, 'moving on' means developing a new sense of self, to replace a troubled self that has existed since childhood. Many clients describe a valued outcome of therapy as being able to possess an internalised voice or presence of their therapist, to which they are able to refer at times of stress. Many clients, even when they report that therapy has been helpful to them, describe being disappointed that they did not get everything they wanted from it, or that they remain troubled by some aspects of their problem. A further distinctive finding to emerge from qualitative outcome research has been confirmation of the existence of fundamental transformational change in some clients – a phenomenon that is not detectable using conventional symptom measures.

Purpose-designed interview schedules that systematically explore the client experience of outcome have been developed by Rodgers and Elliott (2015) and Sandell and Wilczek (2016). Further information on qualitative outcome research can be found in McLeod (2011, 2013c) and further elaboration of the findings from such research is presented in Chapter 1 of the present book.

## Outcome-oriented case studies

Case studies are particularly valuable in establishing the potential effectiveness of new interventions and therapy models, in advance of large-scale evaluation through an RCT or naturalistic study. Hermeneutic single case studies, 'N = 1' time-series case studies, and case series investigations (McLeod 2010) are forms of case-based inquiry that make it possible to establish that an innovative or under-researched form of practice is, in principle, capable of producing positive outcomes for clients. This evidence then provides a rationale for conducting further research with larger samples of clients. An example of this strategy can be found in the work of Widdowson (2016) in relation to the development of a transactional analysis approach to therapy for depression. In addition, because good case studies provide a more in-depth account of what happens in therapy, they also provide a point of comparison or quality check in relation to large-scale studies. Several case studies (e.g. Elliott et al. 2009) have shown that outcome evaluations as measured by standardised questionnaires may produce a different answer than evaluation based on such case material that draws on a variety of sources of information. Examples of how intensive single-case analyses have been used to augment findings from RCTs, and a rationale for this research strategy, can be found in Fishman et al. (2017).

## Surveys

Survey questionnaires that are distributed to members of the public, to investigate questions such as the proportion of people who have received therapy and how beneficial they believe it to have been, have a number of advantages in relation to building a comprehensive understanding of therapy outcomes. All of the other approaches to outcome evaluation discussed in this chapter collect data from clients during their time in therapy, using therapists or researchers associated with the therapy clinic to collect information. By contrast, surveys are generally distributed by consumer or health organisations, and responses are less likely to be influenced by a wish to please the researcher. The best-known therapy outcome survey was the *Consumer Reports* survey conducted by Seligman (1995), which reported highly beneficial effects from therapy. However, such findings might be attributed to the fact that perhaps those who were more positive about therapy were more likely to go to the trouble of completing the questionnaire. An alternative approach, which addressed this methodological issue, was used by Chow et al. (2017). They analysed information collected in routine health surveys administered to large panels of members of the public in Germany and the USA on a regular four-year cycle. Survey participants were asked if they had been in therapy since the previous survey date. What they found was that those who had received therapy recorded higher rates of mental health problems than they had reported at the time of the previous survey. This



suggests that, on the whole, therapy had not been effective in addressing a downward emotional spiral in these individuals. The results of Chow et al. (2017) are strikingly at odds with any other therapy outcome research that has ever been published. On the other hand, it is possible that they were able to access research informants (e.g. dissatisfied therapy clients who had dropped out of treatment, or people who had been seen by therapists lacking in competence) who had not been picked up in mainstream therapy outcome research.

### Box 30.5: The *Consumer Reports* study

*Consumer Reports* is a US magazine that routinely distributes survey questionnaires to its extensive readership, to gauge their views on a range of products and services. In 1994, the magazine included a series of questions in its survey concerning the use of counselling and psychotherapy, and the benefits that readers had experienced from any therapy in which they had participated (Seligman 1995). The main results were as follows:

- Over 80 per cent of those who had used therapy got better (a much higher proportion than in most controlled studies).
- There was no difference in effectiveness between different therapy approaches.
- Those who had received long-term therapy did significantly better than those who had received brief therapy.
- Externally imposed limits on the number of sessions was associated with poorer outcomes.
- Broadly equivalent outcomes to formal psychotherapy were reported by those people who had sought psychological help from clergy, their family doctor, or Alcoholics Anonymous.

A later, parallel study in Germany yielded similar results (Hartmann and Zepf 2003). The publication of the *Consumer Reports* study raised a storm of controversy (Nielsen et al. 2004). Critics complained that the *Consumer Reports* survey used a questionnaire that had not been properly validated, had recruited a biased sample (i.e. those who were particularly happy with the therapy they had received), and that the responses of participants were inevitably inaccurate because they were being asked to retrospectively report on therapy that had taken place months or years previously (Nielsen et al. 2004). On the other hand, some leading researchers carried out analyses suggesting that the findings of the *Consumer Reports* were credible (Howard et al. 2001; VandenBos 1996).

## Structural change

From a psychoanalytic perspective, there are important limitations associated with self-report approaches to evaluating outcome, such as symptom measures, satisfaction scales, and qualitative interviews. While there are plenty of examples of outcome research in psychoanalytic and psychodynamic therapy that have used such techniques (Driessen et al. 2015; Smit et al. 2012), psychoanalytic theory suggests that clients may not be reliably able to describe or report on the most important shifts that have resulted from therapy. In psychoanalytic terms, significant change occurs at the level of personality structure and is expressed in subtle differences in the way that a person relates to others (transference). Some psychoanalytic researchers have used projective techniques to capture such changes, and have also devised a way of using interviews in which the key data come from the interviewer's countertransference response to the interviewee. Further information about these approaches can be found in Stånicke (2011), Stånicke and Killingmo (2013), and Strømme et al. (2010).

## Action research

It is possible to critique most therapy outcome research studies on the grounds that their primary function has been to produce academic articles that are published in research journals, rather than to make a tangible difference to clients and service users. While outcome researchers clearly intend that their work should lead to improvements in therapy, the pathway from research to on-the-ground implementation is a rocky one, and it is not easy to identify specific improvements in recovery rates that are attributable to the application of research findings. Action research offers an alternative approach, in which the aim of research is to facilitate a cycle of continuous service improvement. Each cycle of the research process involves establishing a baseline of practice effectiveness, identifying ways in which services can be improved, initiating change, and then assessing whether these changes have made a difference. Despite the obvious relevance of this form of research (Guiffreda et al. 2011; Hoshmand and O'Byrne 1996; Kidd and Kral 2005; Smith et al. 2010), there are very few examples of published action research projects in counselling and psychotherapy (Buckroyd 2003; L'Etang and Theron 2012; Richardson and Reid 2006). A similar research philosophy is reflected in studies that adopt a collaborative or participative approach in which professionals and service users work together to collect and analyse data in the interest of enhancing service delivery (Cooper et al. 2016; Veseth et al. 2012).

## Outcome research: reflection and conclusions

The topic of outcome and effectiveness represent the largest single area of therapy research, one that has received substantial societal investment over a 50-year period. What have we learned from this massive body of work? The most important finding to have emerged is that therapy helps people. Improvements to mental health and well-being arising from counselling and psychotherapy are substantial, sustained, reliable, and at a level that compares favourably to outcomes of any medical, psychiatric, educational, or social intervention that has ever been systematically evaluated. On the other hand, there is clearly room for improvement. Therapy helps perhaps 60 per cent of those who stay the course. However, more than 20 per cent of clients who start therapy drop out before it has had time to have an effect on them. Therapy is less effective for individuals who experience social disadvantage. There are also a large number of people (including many men) who are emotionally troubled but who do not make use of therapy because they do not view it as credible, or cannot access it.

For the most part, outcome research has been motivated by a drive to answer pragmatic questions such as 'what works?' An unexpected by-product of this area of research is that it has opened up major conceptual or theoretical questions about how we understand the nature of therapy itself. Pim Cuijpers and Bruce Wampold are two leading figures in contemporary psychotherapy outcome research, both of whom suggest that reviews of outcome studies that compare ostensibly quite different models of therapy (e.g. psychodynamic and CBT) generally tend to find equivalence in outcome between therapy approaches (Cuijpers 2016; Wampold et al. 2017). It is important to be clear about how these analyses operate. What they do is pool findings from thousands of clients across many different studies. They are then able to detect (or not) marginal differences in effectiveness that may be apparent. If there were clear-cut differences (e.g. CBT produces a 65 per cent recovery rate while psychodynamic yields one of 55 per cent) the question of equivalence would not arise: there would be a clear winner. The implication, therefore, is that the causal mechanisms that produce change cannot be those that are hypothesised in specific theories of therapy. Wampold and Imel (2015) and others have argued that all forms of effective therapy rely on a set of common helpful factors, such as a confidential relationship with a trusted therapist, instillation of hope, the opportunity to express emotion, and so on. Other evidence suggests that effective therapy depends on the healing qualities of the therapist. At the present time, although we know that therapy is generally helpful for clients, we do not really know what makes it effective, other than that is probably not (in any straightforward way) what mainstream theories of therapy believe it to be.

### Box 30.6: The issue of harmful therapy

The accumulation of evidence about the effectiveness of therapy, using a wide range of methodologies, has been accompanied by a growing interest in the potential harmfulness of counselling and psychotherapy: if an intervention or change process is potent, it has the potential to produce negative as well as positive effects (Barlow 2010; Dimidjian and Hollon 2010). All outcome studies report a proportion of clients (5–15 per cent) whose problems or symptoms get worse over the course of therapy. However, it is possible that these individuals would have deteriorated even further without therapy, or that their negative experience was due to factors outside of therapy. Researchers, therefore, have carried out studies that explore client perception of harm, and the extent to which clients attribute these effects to the therapy they have received. These studies have shown that a substantial proportion of clients report transient negative effects at some point during the course of therapy (Hardy et al. 2019; Rheker et al. 2017; Schneibel et al. 2017). In a large-scale survey in the UK, 5 per cent of clients reported lasting negative personal consequences of therapy (Crawford et al. 2016). Other studies have found that therapists are not good at detecting negative effects (Hatfield et al. 2010). A variety of causes of negative effects have been identified. Among the key factors are therapist defensiveness in the face of client anger and emotionality (Binder and Strupp 1997) and poor therapist skill in working collaboratively (Bowie et al. 2016).

## Research into the process of therapy

Whereas outcome studies mainly examine change in the client before and after therapy, without looking at what actually happens during sessions, process studies take the opposite approach. In a process study, the researcher observes, measures, and analyses the therapeutic elements that are associated with change. Having established that therapy ‘works’ (see previous section), the goal of process research is to learn *how* it works (Elliott 2010).

Process research tends to be of great interest to practising counsellors and psychotherapists, because it focuses on a detailed definition and analysis of things that they do (e.g. offer empathic responses and transference interpretations, use structured homework tasks, mindfulness exercises, or case formulation techniques, work in a time-conscious way, and so on) and, as a result, has the potential to provide a deeper understanding of commonly used therapeutic activities and strategies. However, from a scientific perspective, analysing the process of therapy is extremely difficult. Multiple processes are always occurring at any one time: it is hard to isolate the effect of one specific process without knowing the context within which it is occurring. It is also hard to decide on the most appropriate temporal unit of analysis. For example, is a transference interpretation best analysed as a brief interaction between client and therapist? Or is it also necessary to analyse what has led up to that analysis, or what follows from it? Finally, some processes are within conscious control and can be reported on by clients or therapists (e.g. the therapist’s experience of using a relaxation technique) while other processes, such as word choice, non-verbal synchrony, and autonomic nervous system responsiveness, occur out of awareness.

Many examples of process research are highlighted in other chapters of this book. The aim here is to explore how process research has evolved, both historically and in terms of the strengths and limitations of strategies that have been devised to address the fundamental methodological challenges associated with this area of inquiry.

## Studies of process from a client-centred perspective

The client-centred approach to counselling and therapy developed by Rogers and his colleagues (Rogers 1942, 1951, 1961) was characterised by a consistent emphasis on the process of change in clients,

and the process of the client–counsellor relationship. Rogers and his colleagues at the University of Ohio (1940–45) were the first investigators to make recordings of therapy sessions, and the first to study process in a systematic way. The earliest studies within the client-centred framework explored changes in the ways that clients made reference to self at different points in their therapy, and the ‘directiveness’ of therapist statements, by analysing transcripts of counselling sessions (Seeman 1949; Snyder 1945). Other studies from this period focused on the experience of the client in therapy, for example through the analysis of diaries kept by clients (Lipkin 1948; Rogers 1951).

In a major piece of research carried out at the University of Chicago, Rogers and Dymond (1954) and their colleagues examined different aspects of change in clients’ self-concepts during and after therapy. Self-acceptance, a key concept in Rogerian theory, was assessed using a technique known as the ‘Q-sort’, in which clients arrange a set of self-statements to describe ‘how I see myself now’ and ‘how I would ideally like to be’ (the difference between actual and ideal self being taken as a measure of self-acceptance). Taking a group of 29 clients, they administered the Q-sort, and a range of other tests, at a pre-therapy interview, regularly throughout therapy, and at follow-up. Results showed that changes in self-perception were closely associated with good outcomes. One of the main achievements of this phase of research was to demonstrate that research could be undertaken that was phenomenological, respectful of the experience of the client, yet at the same time rigorous and amenable to quantitative analysis. For the first time, an important aspect of process, change in self-acceptance, had been measured and tracked across a course of therapy. Rogers and Dymond’s (1954) report was also noteworthy in containing a systematic analysis of failure and attrition cases.

Towards the end of his stay in Chicago, Rogers integrated the fruits of research and practice in client-centred therapy and counselling into two key papers, one on the ‘necessary and sufficient’ relationship conditions of empathy, congruence, and unconditional positive regard (Rogers 1957), the other on the process of change in therapy (Rogers 1961). In their next major piece of research, Rogers and his collaborators then set out to test these ideas in a study of client-centred therapy with hospitalised schizophrenic patients (Rogers et al. 1967). Rating scales were devised to measure the therapists’ levels of unconditional positive regard, congruence, empathy, and experiencing in recordings of sessions with clients. Barrett-Lennard developed a questionnaire, the Relationship Inventory (Barrett-Lennard 1964), to assess these ‘core conditions’ as perceived by clients, counsellors, or external observers. Although the results of the schizophrenia study were ambiguous, largely due to the difficulty in achieving any degree of substantial change in disturbed clients, the Relationship Inventory, the Experiencing Scale, and other therapy process measures developed during the project have remained standard instruments in process studies, not only within the person-centred approach, but across the therapy research community (Greenberg and Pinsof 1986).

The process research carried out by Rogers and his collaborators made a significant contribution to the field by demonstrating that the phenomena and processes of the therapy relationship were not something mysterious and elusive, but could appropriately and effectively be opened up for external scrutiny and research. They also showed that it was possible and profitable to give the client a voice, and to explore the experience and perceptions of the client in therapy.

### **Box 30.7: Research into a key aspect of therapy process – the working alliance**

The largest single body of research into the process of therapy has accumulated around the topic of the ‘working alliance’. Originally formulated by Bordin (1979), working alliance theory is a pan-theoretical approach that suggests that the client–therapist relationship comprises three main dimensions: the bond between therapist and client, and agreement over goals and tasks. The Working Alliance Inventory was developed as a brief self-report measure of the alliance that

clients and therapists could complete either before or after a session (Hatcher and Gillaspay 2006; Horvath and Greenberg 1986) and has been used in hundreds of research studies (Muran and Barber 2011). More recently, there have been attempts to reconceptualise the alliance and devise new measures that have a greater focus on the behaviour of therapists around the actual activities and behaviour involved in 'alliance work' (Owen et al. 2013).

## Studies of process from a psychodynamic perspective

Psychodynamic theory contains a wealth of ideas about the process of therapy. For example, psychodynamic work is likely to include processes such as free association, interpretation, transference, countertransference, analysis of dream and fantasy material, and episodes of resistance. Research that helps practitioners to understand more fully the mode of operation of these factors is therefore of substantial practical utility.

However, research that is consistent with the basic philosophical assumptions of psychoanalysis presents a number of distinctive methodological problems. From a psychoanalytic point of view, the meaning of a client statement, or interaction between client and counsellor, can only be understood in context, and can only be fully understood by someone familiar with psychodynamic methods and theory. It is insufficient, therefore, to conduct process studies that rely on tape-recordings of segments of an interview, or to use a standardised rating scale administered by research assistants, as in other process research. As a consequence, psychodynamic process studies have typically been carried out by expert, trained practitioners, and have been based on the investigation of whole cases.

One of the most influential examples of psychodynamic process research is to be found in the use of the core conflictual relationship theme (CCRT) method developed by Luborsky et al. (1986) as a technique for exploring transference. In this technique, a number of expert judges first read a transcript of an entire session. They are then asked to focus on episodes in the transcript where the client makes reference to relationships, and to arrive at a statement of three components of each episode: the wishes or intentions of the client towards the other person; the responses of the other person; and the response of the client themselves. Taken together, these components yield a picture of the kind of conflictual relationships, or transference patterns, experienced by the client in their life. The formulations of different judges are checked against each other to arrive at a consensus view.

The CCRT method has been used to investigate a number of hypotheses regarding the transference process in therapy. For example, Luborsky et al. (1986) compared the transference themes displayed towards other people and those expressed in relation to the therapist. Results provided strong evidence to confirm the Freudian assumption that the transference relationship with the therapist is a reflection of the way the client characteristically relates to people in everyday life. Crits-Christoph et al. (1988), also using the CCRT technique, showed that accuracy of interpretation, assessed by comparing CCRT formulations with therapist interpretations of relationship issues, was positively correlated with client benefit in therapy. Similar studies, in which expert readers have been employed to identify other psychodynamic themes in session transcripts have been carried out by Kächele (1992), Malan (1976), and Silberschatz et al. (1986). The psychodynamic tradition has generated a great deal of research activity, of which the examples discussed in this section represent only a small sample. Further information and examples of research into psychoanalytic and psychodynamic processes can be found in Kächele et al. (2015), Levy et al. (2012), Shedler (2010), and Ulberg et al. (2014).

## The 'events paradigm'

The 'events paradigm' (Rice and Greenberg 1984a) is an approach to process research that concentrates on finding change events within therapy sessions, and identifying the therapist's or counsellor's



actions or strategies that enabled these events to occur. This is quite different from studies of process (e.g. Rogers) that focus not so much on discrete events as on general conditions or the creation of a therapeutic environment. Information about significant events can be obtained through inviting the client or therapist, at the end of each session, to complete a brief form that asks them to describe moments in the session that have been particularly meaningful for them (Cummings et al. 1994; Llewelyn 1988). What happened during these moments can be observed through analysis of a transcript of an audio-recording of the session. This information can then be used to produce evidence around the distribution of significant events over the course of therapy, the characteristics and structure of different types of event, and the therapist's behaviour that appeared to facilitate good (or bad) moments (Llewelyn et al. 1988; Mahrer et al. 1987). Another approach to analysing such data involves building models of the sequence of tasks the therapist and client typically carry out in order to facilitate change in relation to specific issues (Rice and Greenberg 1984b). For example, if a client expresses self-criticism, it is possible to identify sequences of activity that either lead to a successful resolution of that issue, or do not.

Further developments in research that uses the analysis of significant events to investigate the process of therapy can be found in the work of Laco Timulak and his research team (Richards and Timulak 2012; Timulak 2007, 2010; Timulak and McElvaney 2013; Timulak et al. 2010). Unlike Rogerian or psychodynamic process studies, which are explicitly informed by theory, events research is not grounded in a specific theoretical orientation. The aim, instead, is to invite clients and therapists to provide descriptions of their experience, in their own words. Typically, clients describe events that reflect a range of different change processes.

## **The process as experienced by the client: qualitative research**

One of the fundamental issues in research into counselling and psychotherapy concerns the question of who is observing what is happening. Rogers and Dymond (1954) pointed out that different conclusions on process and outcome could be reached depending on whether the perspective of the client, the therapist, or an external observer was taken. Most research has relied on either the perspective of the therapist or that of an external observer, since to involve the client could intrude on their therapy. Most studies that have involved collecting data from clients have used standardised questionnaires or rating scales. In these studies, the experience of the client is filtered through categories and dimensions imposed by the researcher. In order to gain a more comprehensive understanding of the process of therapy, it has therefore been necessary to devise ways of carrying out research into the client's experience.

In one of the earliest studies of client experience, Maluccio (1979) undertook intensive interviews with clients who had completed counselling. He found that, on the whole, clients often attributed changes in psychological and emotional well-being not to anything that was happening with their therapist, but to external events such as getting a job or moving house. As a means of getting closer to the client experience, Rennie (1990) focused on the experiences of clients in single sessions, using the technique of interpersonal process recall (Kagan 1984), to enable clients to re-live or re-experience what they thought and felt during the session. An audio- or video-recording was made of the session. Then, as soon as possible after the end of the session, the client reviewed the recording in the presence of the researcher, stopping it whenever they remembered what was being experienced at that point. The researcher then analysed the transcript of the inquiry interview to identify themes and categories of client experience.

The client experience studies undertaken by Rennie and his associates (Angus and Rennie 1988, 1989; Rennie 1990, 1992) opened up for research an area of the therapy process that is normally inaccessible to therapists, and have produced some striking results. One of the conclusions Rennie arrived at was that clients respond to the therapist on different levels. While they may be telling their therapist about some event in their life, underneath that narrative they may be considering whether or not to take the risk of talking about some previously secret piece of information. Or they may



agree with an interpretation or intervention from the therapist while knowing that it is inaccurate or inappropriate. This line of research has made a substantial contribution to appreciating and understanding the extent to which the client is an active, reflexive participant in therapy (Rennie 2002).

A pragmatic and straightforward approach to exploring the client experience of therapy is to ask the client to describe helpful or hindering aspects of the therapy they have received, using interviews or open-ended questionnaires. Such studies have examined general perceptions of helpfulness over the course of therapy, helpful aspects of specific sessions, or the helpfulness of specific interventions or points within therapy (e.g. case formulation, the ending). An exploration of the methodological challenges and possibilities associated with this type of investigation can be found in Cooper and McLeod (2015). Examples of interesting studies that have looked at different aspects of helpful factors in therapy, using different methodological approaches, are Gibson and Cartwright (2013), Lilliengren and Werbart (2005), and Perren et al. (2009).

Evidence from client experience research has been used to inform Chapter 1 of the present book. Recent reviews of the findings and insights, and practice implications generated by this type of research, are available in Levitt et al. (2016), Swift and Parkin (2017), Timulak and Keogh (2017), and Timulak et al. (2013).

### Box 30.8: Using process research to generate principles for practice

A good example of how research into client experience can be used to inform practice can be found in Levitt et al. (2006). In this piece of research, 26 clients who had recently completed therapy (average length of therapy = 16 months) were interviewed in depth about what had been significant for them in their experience of therapy. The transcripts of these interviews were carefully analysed in terms of emergent therapeutic principles that might provide practical direction for therapists. Some of the principles that were identified in the study included the following:

- Initially, clients may enter therapy with expectations or fears that work against their engagement. If a commitment to therapy does not develop, it may be helpful if clients are guided to frankly discuss their shame or fear of examining threatening topics, or if the relationship is mutually examined.
- The therapeutic environment is experienced as a reflection of therapist care, and can facilitate clients' relating in a more relaxing way.
- Initially in therapy, an increasing dependency on the therapist appeared to allow the client to individuate from significant others, and then it tapered off as the client became more self-reliant.
- Clients tended to develop trust after scrutinising therapists for displays of caring, especially when vulnerable issues arose. Therapists can convey caring by appearing genuine, showing respect for the client's process, and demonstrating faith and expertise in the therapeutic process.

Although the ultimate validity of these principles needs to be evaluated through further research with different groups of clients, the study of Levitt et al. (2006) is notable in providing clients with an opportunity to 'speak to' the professional community of therapists and tell them what they find helpful. It is striking that, at least in this study, clients valued aspects of therapy that tend not to be highlighted in mainstream therapy theory – the therapist as someone who cares, the significance of the therapist's room, and the positive value placed on the experience of feelings of dependency toward the therapist.

### Box 30.9: Are all therapists equally effective?

Most research into the effectiveness of counselling and psychotherapy has looked at the overall, or average, effectiveness of a group of therapists participating in a research study. However, some studies have looked at the relative effectiveness of individual counsellors and therapists (for example, Blatt et al. 1996; Kraus et al. 2011; Lutz et al. 2007; McLellan et al. 1988; Okiishi et al. 2003). Studies of what have become known as ‘therapist effects’ consistently indicate substantial differences in effectiveness across individual clinicians (Wampold and Imel 2015). Some leading figures have argued that these findings suggest that differences in outcome between therapy approaches (e.g. psychodynamic, person-centred, CBT) are minimal compared with differences between individual therapists, and that the whole field of therapy outcome research should pay much more attention to the factors that contribute to the effectiveness (or otherwise) of individual therapists. Other commentators disagree and claim that the data can be interpreted in different ways (Crits-Christoph and Gallop 2006; Elkin et al. 2006; Kim et al. 2006). A collection of papers exploring these issues and debates can be found in Castonguay and Hill (2017).

### Case studies

In the early years when psychotherapy was emerging as an area of professional activity, case studies represented the primary vehicle for the development of theory and practice. The cases published by Freud and his colleagues, which comprised the basic building blocks of psychoanalytic knowledge and training, have been widely read and debated. It would be unusual to find a trained and experienced psychodynamic counsellor or therapist who had not carefully read the cases of Dora (Freud 1901/1979), the Rat Man (Freud 1909/1979), and Schreber (Freud 1910/1979). These cases have also been influential beyond the world of psychoanalysis and psychodynamic therapy.

From a research point of view, however, there are many methodological issues raised by the manner in which Freud and his colleagues carried out case studies. Freud saw several patients each day, writing up his notes of his consultations in the evening. Some of these notes were subsequently worked upon as papers presented to conferences or published in books and journals. At each stage of this process of producing a case study, no check was possible on the validity of the conclusions reached by Freud, or on any bias in his recollection or selection of evidence. Critics could put forward the argument that Freud distorted the evidence to fit his theories. For example, Spence (1989) argued that in a typical psychoanalytic case study, there is a strong tendency for the author to ‘smooth’ the data (i.e. ignore contradictory evidence) to make it fit the theory. There is little that psychoanalysts can do to counter this charge, given the way their case studies have been carried out.

The dilemma that is apparent in this debate over case studies is that, on the one hand, detailed examination of individual cases is invaluable for the development of theory and practice but, on the other hand, finding a rigorous and unbiased way of observing and analysing individual cases is difficult. The construction of methods for *systematic* case study research has been a recurrent concern for researchers in the field of personality for many years (DeWaele and Harré 1976; Murray 1938; Rabin et al. 1981, 1990). Within the field of counselling and psychotherapy research, there have been five distinctive approaches to systematic case study investigation: ‘ $N = 1$ ’ studies, theory-building case studies, quasi-judicial case analysis, narrative case studies, and pragmatic case studies.

Behavioural case studies are sometimes known as ‘ $N = 1$ ’ studies and are associated with the ‘scientist-practitioner’ model discussed earlier in this chapter. These case studies concentrate on tracking changes in a limited number of key variables predicted to change as a result of counselling,

such as the amount of time spent studying or the score on a depression inventory. The principal aim of the study is to demonstrate the effectiveness of a particular type of intervention with a particular category of client; broader process issues are not usually considered. Morley (2007) provides a detailed account of the procedures involved in this type of case study. 'N = 1' case studies, or 'single subject' designs, have played a central role in the development of CBT, by offering practitioners a means of documenting and analysing the effectiveness of innovative interventions, in advance of carrying out large-scale studies.

Other researchers have used case studies in the development of theory (Stiles 2007). A powerful early example of this type of work was the series of eight case studies of brief therapy with depressed women clients carried out by Hill (1989), with the aim of identifying the relative contribution to outcome made by non-specific factors and therapist techniques. This study involved the collection of exhaustive and comprehensive information on each case. Bill Stiles and his colleagues have used systematic analysis of case data in the development of the assimilation model of therapeutic change (Stiles 2005, 2006). A notable recent example of systematic *theory-building* case study research is a series of studies that were carried out with the goal of developing a deeper understanding of the way that therapist immediacy functions in therapy (Hill et al. 2008; Kasper et al. 2008; Mayotte-Blum et al. 2012).

A number of other case studies have been published in which cases of special interest have been selected from large-scale extensive investigations. For example, Strupp (1980a, 1980b, 1980c, 1980d) presented four comparative pairs (one success and one failure case) of cases drawn from Strupp and Hadley (1979), in order to generate a comprehensive understanding of the factors associated with good and poor outcomes.

*Quasi-judicial* case studies represent an attempt to introduce rigour into the analysis of case data by introducing ideas from the legal system. In court cases, the true interpretation of what happened in a crime is determined by the presentation of prosecution and defence arguments, with the final decision being taken by a judge or jury. In similar fashion, in his psychotherapy case studies, Elliott (2002) employs two teams of researchers: one group is given the task of arguing that the outcome of the case is due to the therapy that was delivered, and the other group the task of arguing that any changes that occurred were the result of extra-therapeutic factors. Elliott (2002) suggests that the final conclusions arrived at through this kind of adjudication process are particularly credible, compared with conventional clinical case studies. A particularly well-described example of this kind of case study research can be found in Elliott et al. (2009).

*Narrative* case studies use methods of qualitative inquiry to allow the client and/or the therapist to tell their story of taking part in therapy. Etherington (2000) provides an example of this genre of case study research. If carried out carefully and rigorously, autobiographical, first-person writings may also fit into this category.

A further approach to case study research in counselling and psychotherapy is represented by the *pragmatic* case study. In an influential book, Fishman (1999) argued that case studies comprise a basic form of practical knowledge for therapists, because the work of therapy inevitably involves dealing with individual lives. Fishman (1999) proposed that a pragmatically useful body of research knowledge could be created by practitioners writing up their case experiences in a standardised fashion, and collecting these cases in a single database. The on-line, open access journal *Pragmatic Case Studies in Psychotherapy* has been established to enable such a database to be created, and has published a series of detailed case analyses that provide an invaluable resource for therapists.

There has been a resurgence of interest in case study research in counselling and psychotherapy in recent years. Although the potential value of case-based evidence has always been recognised within the counselling profession, there has been a sense that case studies have too often been used almost as promotional vehicles for authors seeking to market new approaches to therapy, rather than as serious contributions to the research literature. There has also been a concern that, even if a case study in itself provides evidence that is convincing and credible, it is impossible to generalise

from single examples. The development of new methods of systematic case analysis, using quasi-judicial, time-series, and theory-building approaches, and the construction of databases of series of case studies, has gone a long way towards alleviating these concerns.

## Professional knowledge studies

Professional knowledge research consists of studies that seek to document and analyse experience and insights arising from practice as a counsellor or psychotherapist. Such studies make an important contribution to the overall research literature by providing a perspective that acts as a supplement and counterbalance to research that adopts an external-observer standpoint (McLeod 2016). Professional knowledge research draws on a range of methodologies, including interviews (Burke et al. 2016; Potter and Coyle 2017), surveys (Jacobson et al. 2016; Norcross et al. 2017), case studies (Pontes and Pereira 2013), autoethnography (Speciale et al. 2015), and autobiography (Marzillier 2010).

## First-person research

A significant emerging strand within qualitative research has comprised studies in which the researcher seeks to analyse their personal or subjective experience in relation to the topic of the research. Although several approaches to this kind of investigation have been developed (McLeod 2014), the current most widely used method is known as *autoethnography*, which is the use of *auto*-biography as a means of exploring cultural phenomena (*ethnography*). Autoethnographic inquiry consists of a set of techniques for systematically writing about and analysing personal experience (Muncey 2010). As a new form of research, there have been relatively few published autoethnographic studies on therapy-related topics. Examples of the potential contribution of this form of inquiry can be found in the study by Sheach Leith (2009) into the search for meaning after pregnancy loss, the exploration by Meekums (2008) of her journey towards becoming a counselling trainer, and the account written by Brooks (2011) of her personal battle to overcome obsessive-compulsive disorder. At its best, autoethnographic studies are able to generate more intensive and detailed exploration of experience than can be achieved through conventional interview-based qualitative research.

## Ethical issues in therapy research

Most forms of therapy research are associated with at least some degree of ethical risk. For example, in outcome studies in which there is a control group of 'waiting list' clients, the decision is taken to offer help immediately to some people while withholding it from others. In studies of new types of therapy intervention, clients may be exposed to therapy that is not proven, and may even be harmful. If the researcher contacts the client to request that they take part in the study, the knowledge that this person is a client is transmitted beyond the therapist or therapy agency. If a therapist asks their client to participate in a study, the client may be unwilling to do so but may nevertheless comply for fear of antagonising someone upon whom they feel emotionally dependent. In studies where former clients are interviewed about their experience of therapy, the interview itself may awaken a need for further counselling.

The key ethical issues arising from therapy research are avoidance of harm, adequacy of informed consent, and confidentiality. Counselling and psychotherapy research studies carried out in government agencies, such as hospitals or social services departments, or submitted for funding to charitable trusts, need to be assessed by ethical committees, and will need to document in detail their procedures for dealing with ethical issues. Further discussion of ethical issues in therapy research is available in McLeod (2010a, 2011) and Danchev and Ross (2014).

## The relevance of research for practitioners

In a study of psychotherapists in the USA, even though 88 per cent of a sample of 279 therapists had PhDs (which meant that they had received extensive training in research, and had carried out research), 24 per cent reported that they never read articles or books about research, and 45 per cent reported that none of the research articles they read had a significant influence on the way they worked with clients (Morrow-Bradley and Elliott 1986). Similar findings have been reported in other surveys (Cohen et al. 1986; Gyani et al. 2014, 2015).

The existence of a ‘researcher–practitioner gap’ can be attributed to the differing roles and professional interests and values of researchers and clinicians. Therapists typically view research as not providing enough information about the methods of treatment used, instead looking at groups of clients rather than individuals and assessing differences between treatment groups on the basis of statistical rather than practical or clinical criteria for significance (Morrow-Bradley and Elliott 1986; Stewart et al. 2012a, 2012b). In addition, many practitioners do not have access to university libraries, so have little opportunity to keep up to date by reading research articles, which are generally hidden behind publishers’ paywalls.

There have been many initiatives designed to close the research–practice gap, such as the creation of practice research networks (PRNs), which allow clinicians and researchers to work together to pursue research questions identified as being most relevant to them (Barkham 2014; Castonguay et al. 2010; Fernández-Álvarez 2015; Thurin et al. 2012). Another approach has been to encourage practitioners to focus on specific points of contact between research and practice that are relevant to their own learning needs (McLeod 2016).

## The relevance of research for clients

Research into the process and outcome of counselling and psychotherapy is potentially highly relevant for clients and service users, because there is a strong likelihood that research evidence will determine the type of therapy that is offered to them. At the present time, in contrast to fields such as mental health and psychiatry, there is a relatively low level of psychotherapy service user activism in the form of criticisms of published research or demands for specific research questions to be given more priority. Although attempts have been made to engage clients in the co-design of services (see, for example, Cooper et al 2016; Moltu et al. 2018), there have been few initiatives of this type. This situation is almost certain to change in the future. As more counselling and psychotherapy agencies publish information about their success rates, therapy clients will follow the lead of consumers in other fields of life, such as education and healthcare, and become more interested in learning about the strengths and limitations of different therapy options. The lack of client interest in research is probably due to a range of factors, including the failure of therapy researchers to disseminate their findings through mass media, and the unwillingness of therapists to discuss research evidence with their clients. There is evidence that many therapy clients take research findings seriously, and are more interested in research than their therapists think they are (Farrell and Deacon 2016).

## Conclusions

The aim of this chapter has been to offer an introduction to the main themes and methodological issues in therapy research, in a way that will encourage readers to explore this literature for themselves. While sensitive and effective practice involves the capacity to draw on a range of skills and areas of knowledge, within the counselling and psychotherapy profession there is a strong expectation that qualified practitioners will be familiar with the ideas and issues outlined earlier, will have worked out their own position in relation to the areas of research knowledge that are most relevant to their practice, and will have developed strategies for keeping up to date with new research findings.

The material in this chapter is no more than a starting point. Counselling and psychotherapy research literature sits within a wider context of scholarship and inquiry. For example, there exists a massive research literature that is concerned not with therapy processes and outcomes as such, but with the nature of the problems and issues that people bring to therapy. For example, many therapy clients describe their problems as 'depression', and there is a wealth of research into the effectiveness of different approaches to therapy for depression. But there is also a wealth of research into what it is like to be depressed, on different patterns of depression, and on the causes of depression. Being a research-informed practitioner or client involves being willing to make use of the valuable insights that can be obtained from this kind of 'background' research, which has a key role to play in documenting the complexity of factors that may be associated with the problems that often lead a person to seek therapy.

Acquiring valid scientific knowledge about therapy is not an easy or straightforward matter. It is essential to appreciate the strengths as well as the limitations of all research methodologies, and realise that reliable knowledge is attained through open conversation in which all points of view are respected.

We are at a time in the history of counselling and psychotherapy when research has greater significance than ever before. For many years, therapy research operated primarily in an academic sphere, as a kind of think-tank for the therapy industry. Researchers developed new ideas and tested therapy 'products', with a slow and gradual filtering through of their findings into practice. But recently, all this has changed. Governments and other large-scale health providers such as insurance companies are confronted with an ever-expanding list of new health interventions, in the form of new drugs and other physical treatments, at the same time as an ever-expanding patient need arising from an ageing population. Health providers are thus faced with a pressing need to prioritise the delivery of treatments that are shown to work, which are evidence-based in terms of hard research evidence. Applied to counselling and psychotherapy, this policy has meant that policy-makers have looked long and hard at the counselling and psychotherapy outcome literature, in order to target their investment on what 'works' for different conditions. This strategy makes good sense in the context of the way that evidence-based healthcare is organised. But it makes less sense to many therapists and service users, who know (but cannot demonstrate in research terms) that many forms of therapy can be helpful, and that some people require expensive, long-term therapeutic support. What has emerged in recent years, therefore, is a growing sense of urgency and crisis around the role of research in counselling and psychotherapy.



## Topics for reflection and discussion

- 1 Imagine that a counselling agency (e.g. a student counselling service in a college, an employee counselling unit, a couple counselling clinic) has asked you to carry out a study of how much benefit their clients gained from the therapy they received. What would you do? How would you involve service users and therapists in the design and implementation of the evaluation? What ethical issues would need to be considered? How would these ethical issues be dealt with in the design of your study? To what extent would the costs of alternative data collection strategies be a factor?
- 2 What research would you like to see carried out? List three research questions that would be of particular interest to you. Consider how you would investigate these questions from both a qualitative and a quantitative perspective.
- 3 How relevant is scientific research for you in your work as a therapist, or how relevant do you think it might be in your future career as a therapist? In what ways do you see research positively influencing your practice, or in what ways could you see it possibly leading to confusion and poor practice?



- 4 How relevant is scientific research for you as a client or consumer of therapy? In what ways has research evidenced informed the way you make sense of your problems, or the choices you have made regarding which type of therapy might be best for you?
- 5 Read a research article published in a therapy research journal. What are the strengths and weaknesses of this particular study? Does the author arrive at conclusions that are fully justified by the evidence, or can you think of other plausible interpretations of the data that the author has not taken into account?

## Suggested further reading

An expanded account of the topics covered in this chapter can be found in *An Introduction to Research in Counselling and Psychotherapy* (McLeod 2013a). Guidelines for how to carry out different types of research study can be found in McLeod (2011, 2014). Books that explore the contribution that research can make to practice include: *Essential Research Findings in Counselling and Psychotherapy: The Facts are Friendly* (Cooper 2008); *Research in Counselling and Psychotherapy* (Timulak 2008); *Counselling Based on Process Research: Applying What We Know* (Tryon 2002); and *Essential Research Findings in Child and Adolescent Counselling and Psychotherapy* (Midgley et al. 2017). There are several excellent counselling and psychotherapy research journals. The most consistent sources of good quality research articles are: *Journal of Counseling Psychology*; *Journal of Clinical Psychology*; *Psychotherapy*; *Psychology and Psychotherapy*; *Psychotherapy Research*; *Counselling and Psychotherapy Research*.

# Chapter 31

## Making use of different delivery formats to enhance access and effectiveness

<b>Introduction</b>	<b>496</b>
<b>Time</b>	<b>497</b>
Frequency and length of sessions	497
Long-term therapy	498
Time-limited therapy	498
Intermittent therapy	500
Single-session therapy	501
<b>Place</b>	<b>502</b>
Organisational contexts	502
<b>Who can be a therapist?</b>	<b>504</b>
Professional therapists	504
Non-professional counsellors	505
Low-intensity support workers	507
Embedded counselling	507
Self-help groups	508
Peers	509
Therapeutic communities	509
<b>Who is the client?</b>	<b>509</b>
Individuals	509
Couples	510
Families	511
Groups	511
Communities	512

<b>Technologies</b>	<b>513</b>
Telephone	513
Internet	514
<i>Email counselling and psychotherapy</i>	515
<i>Communication by video link</i>	515
<i>On-line therapy sites</i>	516
<i>Text messaging</i>	516
<i>Apps</i>	516
<i>Chat rooms</i>	516
<i>Virtual reality</i>	516
<i>Avatars</i>	516
<b>Self-help materials</b>	<b>517</b>
<b>Combining formats</b>	<b>520</b>
Adjunctive interventions	520
Programmes and communities	520
Stepped care	520
<b>Conclusions</b>	<b>522</b>
<b>Topics for reflection and discussion</b>	<b>522</b>
<b>Suggested further reading</b>	<b>523</b>

## Introduction

The image of therapy that has remained, since Freud, in the forefront of the public and professional imagination has been that of a highly trained professional therapist in their own consulting room, holding a person-to-person conversation with a client or patient on a weekly basis over a period of several months. Within the context of contemporary practice, however, there exist many other possibilities around where and how therapy can take place. As core therapeutic principles and methods have been identified and refined, it has become clear that the process of learning and change can be enabled in many different ways. A key challenge for counsellors and psychotherapists, and the organisations within which they work, is to learn how to embrace the potential of alternative modes of delivery to enable the benefits of therapy to be accessible to as many people as possible, in formats that meet their needs and reflect their preferred ways of learning. At an individual level, the huge diversity of ways in which counselling and psychotherapy can be provided represents both challenges and opportunities for therapists. It can be challenging to make sense of the distinctive strengths and limitations of different modes of delivery, and to develop competence in those formats that seem relevant to one's practice. The opportunity lies in the possibility of finding a professional niche that matches one's values and aptitudes, and allows a therapist to do the best work of which they are capable.

There is a range of options around how to deliver therapy. As a way of making it possible to reflect on underlying issues, the material in this chapter is mainly organised around four broad categories: time, place, people, and technology. Towards the end of the chapter, some further variants are discussed that do not readily fit into any of these categories. It is important to acknowledge that the aim of the chapter is limited in scope – to offer an outline of the distinctive features of various

therapy formats, and provide some signposting to where to learn more about them. Because the topic of alternative therapy delivery formats has received little attention within the professional and research literature, there has been an absence of critical discussion and the coverage that is available is somewhat fragmented. This is unfortunate, because from the point of view of clients seeking help, and also the needs of society as a whole to be able to access cost-effective services, these are important matters.

## Time

The length of time that is spent in therapy, and the way in which that time is divided up, have a bearing on all aspects of the process and outcome of therapy. Folk wisdom and common sense tell us that people need to change at their own pace. Some people who enter therapy have been horrifically emotionally damaged by life experiences and need a lot of time – perhaps the rest of their lives – to heal and to be able to learn how to trust. On the other hand, it is clear that, in some instances, long-term therapy can become a form of dependency, or of becoming stuck. A common characteristic in many people who seek therapy is a tendency to avoid difficult situations and emotions. For such individuals, a therapy that moves along at a brisk pace may have many advantages. There are other time issues that are rooted in the structure of a person's life. A student may only be able to attend counselling during term-time. A person with fear of flying may want to be able to travel to an imminent family wedding on another continent. The following sections unpack these and other aspects of the use of time in therapy by exploring how different forms of therapy practice use time in different ways. Attitudes to time may be linked to assumptions about change associated with particular approaches to therapy. A willingness to be flexible, and to negotiate the duration and frequency of therapy sessions, is consistent both with collaborative models of therapy and also a non-directive or person-centred approach. By contrast, therapist-defined time boundaries, which contribute to the creation of a strong therapeutic 'frame' or holding environment, are characteristic of psychoanalytic and psychodynamic approaches.

## Frequency and length of sessions

Most counselling and psychotherapy on offer, around the world, is structured around 50- to 60-minute meetings with a therapist, held once a week. This way of doing therapy is so widespread that it is generally taken for granted and seldom questioned. It is also a structure that makes it easy to organise room bookings and appointment systems. However, there are many other types of time-slot that have been used in therapy. Turner et al. (1996) report a successful experiment, in a student counselling service, in which they retained the same number of sessions, but reduced the length of each session to 30 minutes. They found that clients seemed to gain just as much from these shorter sessions. In some in-patient facilities, clients may be able to access their therapist for several short periods of time each day. In open dialogue therapy (Seikkula and Arnkil 2006), group meetings may go on for an indefinite amount of time. Some therapy approaches advocate the use of a long initial meeting, perhaps extended to three hours, as a way of establishing a solid contact with a new client from the start (see, for example, Barkham et al. 2017). Some therapists use longer blocks of time to increase the emotional intensity of the work. For instance, in their work with clients suffering from chronic obsessive-compulsive disorder, Bevan et al. (2010) found that it was helpful to offer day-long sessions that allowed the clients to be exposed to feared situations within a context of sufficient support. In therapeutic communities and some forms of outdoor and adventure therapy, clients and therapists may live together for days at a time.

The frequency of meetings with a therapist can also vary. Traditionally, psychoanalysis involves four sessions each week. Such an arrangement brings therapy into the heart of the everyday life of the client, because they need to structure their life around their therapy times and will often have pressing

immediate concerns that dominate a session. In addition, the therapist gets to know the rhythms of the client's life. By contrast, in therapy that is provided through fortnightly or monthly meetings, the focus may be much more on taking stock and reviewing and supporting the self-change efforts of the client. Some therapists have created appointment systems through which clients can vary the frequency of appointments, depending on what they believe is most appropriate at a particular stage of treatment, or to take account of other things that are happening in their lives (Carey 2016).

## Long-term therapy

The earliest forms of psychotherapy, such as psychoanalysis, typically involved long-term contracts between therapist and client that might last for years. More recently, there has been a tendency to assume that therapy will be fairly brief, usually less than 20 sessions. This shift has been driven by a variety of influences, such as high demand and pressures to reduce waiting times, as well as the development of effective models for time-limited work. In addition, for practical reasons linked to the realities of data collection, most research into the effectiveness of therapy has focused on fairly brief, time-limited interventions. As the field of therapy as a whole has become more research-informed, this has led to the gradual adoption of empirically validated practice manuals and protocols that disseminate brief therapy approaches for a range of problems. In the light of these trends, there is a risk that the value of open-ended, long-term therapy might not be sufficiently appreciated. Evidence for the usefulness of long-term therapy can be found in autobiographical accounts of the lives of therapists, many of whom describe seeing the same therapist over many years (see Geller et al. 2005). Further evidence exists within the professional community in Germany, which has retained a commitment to the use of long-term therapy as an option for some clients. A summary of research carried out in Germany on the outcomes of long-term therapy is available in Huber and Klug (2017). A study by Morrison et al. (2003) in the USA reported that therapists in private practice saw clients for many more sessions than recommended in research-based protocols.

There are many clients for whom long-term therapy may be the only way that meaningful change can take place. Some people have had childhoods marked by physical, emotional, or sexual abuse and cruelty that have left them unable to trust, and highly anxious in any social situation that involves intimacy. For such people, it may take many months to learn to trust a therapist sufficiently to begin to talk about their life experiences, and further time to develop new and different ways of relating to others. Other people who seek therapy may have multiple problems ('co-morbidity') that need to be worked through one after the other. Others may be so socially isolated that it is extremely difficult for them to translate what they have learned in therapy into new ways of being in the world. People who are living with long-term health conditions such as diabetes, multiple sclerosis, or heart disease, or with a disability, may experience setbacks and stress on a regular basis, and benefit from ongoing psychotherapeutic support.

There are also risks associated with long-term therapy. Sometimes a therapist has taken a client as far as they can, and further progress may require time out or working with a different therapist. It is possible that the emotional security provided by their therapist may inhibit a client from taking risks in their everyday life. And a therapist might deflect a client from talk of ending because they represent a valuable source of income.

## Time-limited therapy

Most counselling and therapy takes place within a fairly limited number of sessions: many studies have shown that the average number of sessions that clients receive, even when an open-ended contract is offered, is around six to eight. These findings, as well as other theoretical, pragmatic, and cost considerations, have led to the development of several forms of 'brief' or 'time-limited' therapy' in which the number of sessions available to the client is defined from the outset. Brief therapy approaches have been developed within all of the major orientations to therapy – psychodynamic, cognitive-behavioural, and person-centred.

Some researchers and practitioners have addressed the question of how just a few sessions are required to enable effective therapy to take place. The attraction of very brief counselling is that its implementation can avoid the problem of long waiting lists. In addition, clients may also be encouraged and given hope by the assumption that they can make progress quickly. Some of the earliest research on this topic examined the efficacy of a '2 + 1' model. In this approach, clients were offered two sessions one week apart, then a follow-up meeting around three months later (Barkham and Shapiro 1990). Initial results, based on counselling offered to white-collar workers referred for job-related stress and relationship difficulties, suggest that at six-month follow-up, around 60 per cent of clients exhibited significant benefits. Another variant on time-limited counselling has been to 'front-load' sessions, with perhaps three sessions in the first week, one in the second week, and then a final session one month later (Zhu and Pierce 1995).

The practice of structuring counselling around time limits makes special demands on therapists, and requires careful training and supervision. It is essential for therapists and therapy agencies employing time-limited approaches to organise themselves to enable effective and sensitive selection of clients, and appropriate referral of clients who turn out to require more long-term therapy. From the wide array of theory and research into brief therapy, some central principles for time-limited counselling and psychotherapy can be identified. These include:

- an initial assessment of clients in terms of readiness and appropriateness for short-term work;
- engaging the active involvement and cooperation of the client, using homework assignments or behavioural experiments, for example;
- finding a specific focus for the therapy, rather than seeking to address underlying personality issues;
- adopting an active approach, which provides the client with new perspectives and experiences;
- structuring the therapeutic process in terms of stages or phases, each of which is associated with a specific aim or focus;
- making strategic use of the ending of therapy to consolidate gains and explore possible implications of that ending and loss of the therapist for the life of the client.

These general principles are implemented in slightly different ways by different approaches to therapy. Further information about how brief and time-limited approaches work in the context of psychodynamic counselling and psychotherapy can be found in Chapter 7. Much cognitive-behavioural therapy is delivered in accordance with treatment manuals or protocols that specify a set number of sessions, and provide guidance on what should happen in each session. Other approaches, such as solution-focused, narrative, and family therapy, have a tradition of working within a limited number of sessions.

One of the key questions in relation to time-limited therapy concerns the issue of how much is enough? In response to waiting lists and funding constraints, many counselling services have adopted a policy of imposing a fixed limit of six or fewer sessions. For most clients, it is unlikely that so few sessions will be sufficient to bring about meaningful benefit. Hansen et al. (2002) reviewed a large number of studies that tracked the number of sessions that were required to achieve clinically significant change in 50 per cent of clients. They found that for people with moderately severe problems, between 10 and 20 sessions were required on average. For clients who had more severe problems (e.g. early trauma or multiple diagnoses), more than 20 sessions were necessary to ensure meaningful and lasting clinical benefit. Hansen et al. (2002) concluded, on the basis of these findings, that some therapy providers may be risking harm to clients by creating the hope of effective help but then not providing enough sessions for that help to be delivered. There are complex ethical and moral issues here. In practice, the consequence of allowing some clients to remain in therapy for a long time may be growing waiting lists, thus prolonging the distress of potential clients and their families. In addition, long-term therapy may be more comfortable (and, in private practice, more lucrative) for therapists – short-term therapy is harder work.



Ethical considerations also lie behind the use of client assessment in many forms of brief therapy. It may be harmful for clients with severe and enduring problems, or painful issues that may evoke distress if opened up, to be offered a restricted number of sessions. This difficulty can to some extent be addressed by making sure that the client is informed about the risks involved and gives consent. However, service users who have had no prior experience of therapy may not be able to appreciate or anticipate in advance how they might feel if a helpful therapy process is brought to a premature end. Another strategy is to ensure that there is somewhere else that a client can approach for further help after they have completed a course of brief therapy.

It is important for therapists and service managers to be clear about the reasons for adopting a brief therapy mode of delivery. Brief therapy seems to be most appropriate when: the agency deals with clients who in the main present with problems arising from life events; assessment or intake procedures are in place to identify clients who require long-term therapy contact; therapists have received training in brief therapy and are ideologically in tune with this approach; the agency seeks to avoid long waiting lists (i.e. there are few other therapy resources available to clients).

Introducing time-limited counselling solely because of resource factors may not represent a cost-effective option. Csiernik (2005) reviewed the policies of a large sample of workplace counselling and employee assistance providers in Canada, in respect of 'capping' of the number of counselling sessions allocated to clients. He found that there was no difference in the average number of sessions (about five) between providers who had limits and those where the client and counsellor were free to negotiate the length of therapy. One of the implications of Csiernik's (2005) results is that, where session limits are introduced, there may be a tendency for some clients to take up *more* sessions than they need; for some clients, beneficial change may happen in the first one or two sessions, but if they have been told that counselling consists of a six-session package, they may continue to attend later sessions that they don't need. The increasing use of client feedback and tracking systems to monitor client progress in therapy (Lambert 2010a, 2010b; Miller et al. 2016) provides an effective means of ensuring that clients receive the number of sessions that they need. When therapists and therapy agencies use such tools, it becomes possible to use outcome data to initiate a conversation about ending.

## Intermittent therapy

An assumption that informs most counselling and psychotherapy practice is that the aim is to offer each client a complete therapy 'episode' that seeks wholly or substantially to resolve the problems for which they are seeking help. The American psychotherapist Nicholas Cummings has argued for many years that this assumption is often misguided. He suggests, instead, that it is more realistic to take the view that a person with a problem will address aspects of that difficulty in a piecemeal fashion, at different times, depending on their life situation and opportunities for change at that particular moment (Cummings 2007, 2008; Cummings and Sayama 1995). This approach has been described as brief, intermittent therapy throughout the life cycle, and is based on a concept of 'interruption, not termination' – from the outset, the client is told that the therapy will pause when they believe that they have gained enough to proceed with their life at that point, but that they are welcome to return whenever they might wish to continue. Cummings and Sayama (1995) describe cases in which there have been gaps of as long as 20 years between therapy sessions. Although the intermittent therapy developed by Cummings (2007, 2008) adopts a highly active approach to therapeutic change, based on behavioural experiments, Smith (2005) has written an account of a form of intermittent therapy that draws on psychodynamic principles.

There would appear to be at least two significant advantages associated with intermittent therapy. First, the client is positioned as a person who is empowered, someone who has the ability to make important decisions about their treatment. Second, the incompleteness of the therapy experience, and the fact that the person knows that they can return to see their therapist at a future time, seems to help clients to remember what it was that they learned in therapy, and make use of this

learning on a day-to-day basis, rather than sealing off the therapy in their memory as something that is complete and over and done with. The practice of intermittent therapy also has a number of implications for practitioners. Obviously, it is not possible for any one therapist to commit to remain working in the same locality for the whole of their career, and so a form of record-keeping needs to be introduced that allows a colleague from the same agency to pick up on the work with a client at the point where they return for further therapy. In effect, the model of intermittent therapy invites counsellors and psychotherapists to be more like general practitioners or family physicians, rather than surgeons – in other words, to build their practice around an assumption of ongoing contact with a person through different stages of their life.

## Single-session therapy

A widely used therapeutic strategy for using time in an effective and intense way is single-session therapy. The earliest published examples of this kind of approach can be found in the work of Rosenbaum (1994) and Talmon (1990). Rosenbaum (1994) focused on the effects on clients of offering single-session counselling. At the beginning of the first session, clients were told that, although they could have more sessions if they needed them, the intention was to work as hard as possible within the forthcoming session to resolve the client's difficulties. At the end of the session (which was allowed to extend to 90–120 minutes), clients were asked if they needed further sessions. Fifty-eight per cent of clients opted for the single session. When contacted at one-year follow-up, 88 per cent of these clients rated their problems as improved or much improved. Important features of this approach were that it empowered clients by giving them choice in relation to the number of sessions, and that the initial introductory statement conveyed positive expectations and hope. This study also illustrates one of the key principles of single-session therapy – that the intention of the therapist is to make the best use of whatever time is available.

The apparent effectiveness of single-session therapy raises many questions for therapists – and therapy organisations – who take it for granted that clients will attend for several sessions. No matter how a counselling service is organised, many clients will attend only once. In general, counsellors and psychotherapists tend to believe that such clients have failed to engage with the therapy process and have not been helped. However, research that followed up single-session clients found that at least half of them were satisfied with the counselling they received (Talmon 1990). In addition, there is a need for counselling and psychotherapy that is available on demand, without the requirement or expectation for continued attendance. Some people who opt for single-session therapy are in crisis and have an urgent need for support and guidance. Others may merely wish to make use of a therapeutic consultation without needing to commit themselves to ongoing treatment, or go on a waiting list. Single-session therapy has been implemented in a range of individual therapy and family therapy community-based services, in therapy centres for young people, and in student counselling settings. Often, this type of provision is called a 'walk-in' service. An emerging form of single-session practice has been developed around the use of synchronous on-line counselling (Rodda et al. 2015).

There has been a substantial amount of research into the acceptability and effectiveness of single-session therapy. For example, Perkins (2006; Perkins and Scarlett 2008) found that a single-session therapy service for young people in Australia produced outcomes that were equivalent to those achieved in long-term therapy, and that clients and their families were satisfied with what they had received. Other evidence for the effectiveness of single-session therapy can be found in Ewen et al. (2018), Hymmen et al. (2013), and O'Neill (2017).

In designing a single-session service, it is necessary to work on the basis that the session might last up to two hours. The therapist also needs to implement strategies for preparing the client, ensuring that the client is suitable for a high-intensity session, identifying a focus for the session, and ensuring the safety and well-being of the client. Useful descriptions of the issues that need to be taken into consideration when operating such a service can be found in Miller and Slive (2004) and Hoyt et al. (2018). Dryden (2017) has produced guidelines for doing single-session CBT therapy that

are also valuable for therapists who use other approaches. Key sources of further information on the use of single-session approaches, including many examples of how they operate in different contexts, can be found in Hoyt and Talmon (2014), Hoyt et al. (2018), Slive and Bobele (2011), and Young et al. (2012). It is important for all counsellors and psychotherapists to be aware of the possibilities of single-session work, whether or not they explicitly specialise in this approach, because it is likely that a substantial proportion of their clients will attend on only one or two occasions.

## Place

The physical place where therapy happens can have a profound impact on the therapy process and the outcome for the client. In recent years, the emerging discipline of 'emotional geography' (M. Smith et al. 2009) has generated a wealth of insight into the ways in which mental health, well-being, and emotional healing are shaped by the locations in which people live and where they receive help. Sections in other chapters of this book explore the relevance of the layout and furnishing of therapy rooms and the possibilities associated with conducting therapy out of doors. However, the most significant aspect of 'place', for therapy clients, is the fact that they visit, and make use of, an organisation that operates in a particular way.

## Organisational contexts

Organisational factors in counselling and psychotherapy services can exert a strong influence on both clients and staff. Much of the counselling and psychotherapy literature ignores organisational issues and is written as though the most common type of therapy organisation is the private practice – with a minimal organisational structure and no hierarchy. Although private practice may represent an ideal for many practitioners, in that it maximises the freedom of the therapist, it accounts for a relatively small proportion of all counselling and therapy that is on offer. Most therapy is provided through larger organisations.

The field of counselling includes many 'voluntary' or 'third sector' agencies, which make use of unpaid or minimally paid volunteers and which, originally at least, were set up to fulfil a social mission. One of the main voluntary counselling agencies in Britain is Relate (formerly the National Marriage Guidance Council), which was formed in 1947 in response to what was perceived as a crisis in married life (Tyndall 1985). Similarly, Childline was formed as a telephone counselling agency in Britain in 1986 in response to general concern about the rising prevalence of child sexual abuse. Relate and Childline are both large agencies, with substantial budgets and hierarchical organisational structures that encompass central management, decision-making and fund-raising functions, as well as local branches. Many other voluntary counselling agencies are much smaller. For example, in many cities there are locally based gay and lesbian counselling networks, women's therapy centres, counselling services for young people, rape crisis centres, and bereavement counselling agencies. Some of these smaller voluntary agencies may be run by fewer than a dozen volunteers.

The difference in size between the large national voluntary agencies and the smaller local ones has implications in terms of organisational structure and functioning. For example, large organisations inevitably need to develop bureaucratic procedures, whereas smaller agencies can rely on decision-making in face-to-face meetings of those involved. On the other hand, the larger agencies are often better placed to afford and provide good quality selection procedures, training, and supervision. There are also common organisational issues found in all voluntary agencies, regardless of size. These include: integrating the efforts of a small group of core professional staff with those of a large workforce of volunteers; maintaining standards with minimally trained volunteers; dealing with the demands of volunteers to be able to enter paid, professional positions; raising money from clients without jeopardising access; and expending effort and energy on collecting charitable donations from the public. Lewis et al. (1992) have documented the operation of these organisational processes and pressures during the evolution of Relate/Marriage Guidance.

A significant amount of counselling and psychotherapy is provided by therapists employed by national statutory agencies, such as the NHS in Britain. There are a range of general organisational issues encountered by counsellors and psychotherapists working in statutory settings. One of the most basic issues is that the ethos or philosophy of the organisation may be in tension with the values of a psychotherapeutic approach. For example, in some NHS settings, the dominance of the medical/biological model may make it difficult for therapists to be accepted who work with relationships and feelings. Large bureaucratic services may be organised around targets and procedures that are hard to reconcile with the needs of clients. Managers may have little knowledge or understanding of therapy. Management structures and priorities may be influenced by neoliberal political ideas in the form of New Public Management. In some situations, legal requirements to act as agents of the court or the State may make it difficult or impossible to offer clients the kind of voluntary, confidential relationship that is usually considered essential in therapy. There may also be rivalry or jealousy on the part of colleagues who regard emotional support and counselling as part of their own role. Many of these challenges can be associated with the intrinsic nature of inter-professional work, which occur whenever specialists work alongside colleagues from other professional groups who have their own roles, norms, and organisational 'territories'. There exists a substantial interdisciplinary literature on such issues.

A final type of organisational setting is where counselling is made available to employees of large organisations. For example, many police forces, insurance companies, and other commercial and service organisations have recognised that counselling is a valuable means of taking care of their 'human resources' – their employees. One of the distinctive aspects of employee counselling schemes, often known as 'employee assistance programmes' (EAPs), is that counselling is set in an organisational context that is not primarily focused on caring or helping people. The tension between the values and philosophy of the organisation and those of the counsellor can be even more acute than in statutory health and social services agencies, and many of the issues highlighted above may apply here too. Employee counselling can be provided 'in-house' by counsellors employed by the organisation, or can be delivered 'out-of-house' through an external counselling agency under contract to the organisation to supply counselling for its employees. In either case, the counselling will be paid for by the employer rather than the client themselves, which can lead, for example, to client suspicion over confidentiality and pressure on the counsellor to produce results consistent with the needs of the organisation rather than those of the client.

The field of organisational studies or organisational behaviour is a well-established area of research and practice that offers a range of perspectives relevant to the understanding of organisational factors in therapy (see, for example, Robbins et al. 2010). Aspects of organisational theory that are particularly relevant to counselling and psychotherapy services include the idea of the organisation as an 'open system', the analysis of organisational cultures and values, and the significance of gender issues. In addition, some writers on organisations have suggested that organisational culture operates largely at an unconscious level: members of organisations may hold powerful fantasies about other people or groups in the organisation, or their clients. According to this theory, the most fundamental elements of the culture of an organisation are unconscious and are revealed only through fantasies, jokes, and other non-conscious processes (Crandall and Allen 1981; Menzies 1959). Another important consideration is the *developmental history of an organisation*. For instance, many counselling agencies begin their existence with a strong sense of mission and commitment. As time goes by, however, the original excitement and sense of mission becomes diluted by the requirement to provide a service to clients. The agency then begins to move into a professional, 'service agency' stage, where expertise and professional competence are valued over commitment and passion, and the work of the agency becomes consolidated and routinised (Hirschhorn 1978). Other organisational researchers have investigated the ways in which organisational stress is mitigated by positive features such as support from colleagues, realistic workloads, clarity about job roles and demands, variety and creativity in the job specification, and recognition and positive feedback from clients and management (Leiter et al. 2014).

A review by Falkenström et al. (2018) established strong evidence that different organisational cultures were associated with different levels of client outcome. Other studies have started to tease

out the specific processes that contribute to such effects. Goldberg et al. (2016) examined the ways in which agency policies could support therapists to become more effective in their work with clients. Rizq (2012) has analysed organisational procedures that inhibit therapeutic relationships in the Improving Access to Psychological Therapies (IAPT) initiative in NHS England. De Jong and de Goede (2015) have shown that the ability of therapists to use client feedback productively is influenced by the extent to which their values fit with the culture of the organisation that employs them. In a clear demonstration of the ways in which such organisational factors create a 'place' where clients can feel safe and welcomed (or otherwise), Kehoe et al. (2016) and Sandage et al. (2017) have shown that the level of administrative hospitality experienced by clients was linked to improvement in therapy.

## Who can be a therapist?

The existence of a strong and secure therapeutic relationship, and the sense of an alliance between the client and therapist around the kind of work that needs to be done, are fundamental elements within all forms of therapy practice. The different therapy approaches and traditions, reviewed in Part 2 of this book, provide alternative ways of how that relationship can function, together with a range of therapist relational styles. However, these approaches seldom address the question of *who* the therapist is, in terms of their identity, role characteristics, and position within society. The position of the therapist is important because, from the perspective of the client, at some level their therapist represents the caring face of the community as a whole. For example, it may mean something quite different to a woman to see a clinical psychologist employed by the public health service (a distanced technical expert) compared with a counsellor working in a women's centre for survivors of sexual violence (a fellow sufferer who offers solidarity in the battle against an oppressive, sexist, and patriarchal society).

The question 'who can be a therapist?' represents a recurring theme in the history of counselling and psychotherapy. The first generation of psychoanalysts were all medically trained, and one of the major achievements of the psychology profession in the USA in the 1940s, led by Carl Rogers, was to gain official recognition for non-medical psychotherapists. More recently, there has been debate around the need for therapists to undergo a full professional training, or whether 'paraprofessional' therapists – who have limited training but adhere to professional standards – are able to do a competent job.

## Professional therapists

Much of the therapy literature and training is based on an assumption that a therapist is someone who has undergone several years of training and is working in a paid, full-time position. It is difficult to determine the proportion of therapy contacts that are in fact delivered by such individuals. Much therapy is provided by helpers who have received limited training. In addition, because of the personal and emotional pressure associated with seeing a significant number of clients each week, many professional therapists develop portfolio occupational roles, for example earning a living as therapy trainers, supervisors, researchers, and writers alongside their work with therapy clients. There are also therapists who maintain parallel occupational roles in quite different disciplines, such as being an artist, musician, doctor, complementary therapist, lawyer, social worker, administrator, gardener, or shop worker, or who work part-time as a therapist because of carer and parental responsibilities. In many places it can be hard to find a full-time job as a counsellor or psychotherapist, or to sustain a full-time private practice. Because of all these factors, professional therapists are not a homogeneous group, but instead are individuals with differing degrees of professional involvement. Professional therapists also differ in terms of the autonomy they enjoy. For example, while some private practice therapists are able to develop their own personal therapeutic style, many therapists working in healthcare organisations are required to function within tightly defined protocols.



## Non-professional counsellors

Many therapists never undergo the intensity and length of training associated with full professional status. Typically, these therapists work on a part-time basis with a particular client group. At the present time, there is no single agreed term to describe this category of therapist. Some of the terms used in the literature include non-professional, paraprofessional, volunteer, or lay counsellor. While the term 'non-professional counsellor' is not ideal, because it is a definition based on a negative, it is probably the most inclusive title available. The key characteristic of non-professional counsellors is that they do the same kind of work as professional counsellors or psychotherapists, but without the same training or scale of payment.

A crucial yet controversial aspect of non-professional counselling is that research evidence suggests that, in relation to client outcomes, non-professionals tend to achieve the same results as highly trained professional therapists (Berman and Norton 1985; Durlak 1979; Hattie et al. 1984; Karlsruher 1974). Over the years, other research studies (Bright et al. 1999; Burlingame and Barlow 1996) and reviews (Christensen and Jacobson 1994; den Boer et al. 2005; Faust and Zlotnick 1995) have essentially arrived at the same conclusion. Only one review (Stein and Lambert 1995) has reported that training had an effect on effectiveness, but the studies reviewed by Stein and Lambert looked mainly at the effectiveness of psychologists at different stages of their training, rather than comparing paraprofessional and professional helpers.

It is necessary to be cautious when interpreting the results of these studies. For example, they cover a wide range of client groups, including psychiatric patients, people with schizophrenia in the community, people in crisis, students with study problems, and children with behavioural difficulties; the non-professional helpers included adult volunteers, the parents of children with behavioural difficulties, and college students; and modes of treatment have encompassed one-to-one and group counselling, behavioural methods, and telephone counselling. So although the general effectiveness of non-professionals has been demonstrated, there is insufficient research in specific areas to allow the claim that the efficacy of using volunteers for that specific client group has been established. Moreover, when the factors that are associated with effective non-professional counselling are considered, some interesting results emerge. Non-professionals who are more experienced and have received more training achieve better results (Hattie et al. 1984). Non-professionals did better with longer-term counselling (over 12 weeks), whereas professionals were comparatively more effective with short-term work (one to four weeks) (Berman and Norton 1985).

Why do non-professionals achieve such good results? Discussion of this issue has generated a number of possible contributing factors:

- They are perceived by clients to be more genuine.
- They are less likely to apply professional labels to clients.
- They restrict themselves to straightforward, safe interventions.
- Clients will attribute success and progress to self rather than to the expertise of their therapist.
- They are able to refer difficult cases to professionals.
- They have a limited case-load.
- They are highly motivated to help.
- They may be more likely to come from similar cultural background as the client.
- They are able to give more time to clients.

This list, derived from the writings of Durlak (1979) and Wills (1982), indicates that there are advantages associated with non-professional status and a relative lack of experience that balance the advantages conferred by professional authority, experience, and advanced training. There are also disadvantages associated with expertise, such as the danger of burnout due to overwork, and the development of professional distancing or detachment from clients. One possible explanation for



the effectiveness of non-professional counsellors may be that they are selected from a pool of naturally talented, untrained listeners and helpers in the community.

Barker and Pistrang (2002) have suggested that psychotherapeutic help can be viewed as existing on a continuum, with highly trained professional therapists at one end, supportive family and friends at the other, and paraprofessional helpers somewhere in the middle. In a unique piece of research, Towbin (1978) placed an advertisement in the personal column of his local paper to seek out non-professional 'confidants'. The entry began, 'Do people confide in you?' Towbin interviewed 17 of those who replied. These people were self-confident and open, and had felt deeply loved as children. With regard to the relationships with those who confided in them, they saw themselves as trustworthy and able to be fully present in the situation.

Another factor that is significant in at least some paraprofessional counselling is that the counsellor is drawn from the same social and cultural group as the clients they see, and as a result are readily able to appreciate the life challenges being faced by their clients and what possible solutions are available. This kind of counsellor–client social matching was a key element in the well-known Vanderbilt study (Strupp and Hadley 1979). It was also central to the success of a project in which depressed women in Karachi, Pakistan were provided with counselling from minimally trained volunteers from the same community (Ali et al. 2003).

An important area worthy of further research is the relationship between professional and volunteer counsellors. For example, in Strupp and Hadley's (1979) study, the college professors acting as counsellors were all carefully selected by professional therapists, and had the option of passing clients on to the university counselling service. Clearly, professionals are heavily involved in volunteer counselling schemes through delivering training and supervision, and in taking referrals for clients whose difficulties are beyond the competence of volunteer counsellors.

Little is known about the distinct training and supervision needs or the development of skills and awareness of volunteer counsellors. Another useful area of inquiry concerns the theoretical basis for volunteer counselling. Non-professionals with limited time to attend courses or explore the literature often lack a consistent theoretical orientation, even though they may possess good counselling skills, and may struggle when asked to deliver technically complex protocol-driven interventions (Bright et al. 1999). It is significant that theoretical models typically employed in training courses for volunteers, such as the Egan (2009) skilled helper model, are broadly integrative and action-oriented rather than exploratory in nature.

Despite substantial evidence of the potential effectiveness of therapy delivered by non-professionals, there has been a lack of research on this topic in recent years. In part this is because it has become clear that many so-called non-professional therapists are in fact individuals on a trajectory towards professional status (see, for example, Armstrong 2010). And in part it reflects the nature of complex debates around the status and meaning of volunteering (Bondi et al. 2003; Hallett et al. 2012). An additional contributory factor is the extent to which non-professional therapists represent a threat to established professions in terms of not only remuneration and job security, but also perceived dilution of professional standards.

### **Box 31.1: Research into the effectiveness of paraprofessional counsellors – the Vanderbilt study**

Probably the most detailed piece of research comparing professional and non-professional counsellors is the study carried out by Strupp and Hadley (1979) at Vanderbilt University in Nashville, Tennessee. In this study, male college students seeking counselling were assessed using a standardised personality questionnaire. Those who exhibited a profile characterised by depression, isolation, and social anxiety were randomly allocated either to experienced therapists or

to college professors without training in counselling who were 'selected on the basis of their reputation for warmth, trustworthiness, and interest in students' (Strupp and Hadley 1979: 1126). A comparison group was formed from prospective clients who were required to wait for treatment. The effectiveness of the counselling (twice weekly, up to 25 hours) was evaluated using standard questionnaires and ratings administered at intake, termination, and one-year follow-up. In addition, sessions were either video- or audio-taped.

The two treatment groups showed more improvement than the control group, but there was no difference in outcome between those clients seen by experienced therapists and those counselled by untrained college professors: the non-professional counsellors proved to be just as helpful as their professional colleagues. Strupp (1980a) describe the example of a professor of statistics who was genuinely interested in his clients, offered high levels of encouragement and acceptance, and communicated a sincere belief in their capacity to change for the better. With clients who were ready to try out new behaviours he proved to be a highly effective therapist. With one of his more difficult clients, a young man who turned out to have deep-rooted difficulties arising from his relationship with his father, therapy broke down because of the counsellor's inability to understand or challenge high levels of resistance and negative transference on the part of that client.

## Low-intensity support workers

Self-help packages, in the form of books and manuals as well as on-line materials, and 'stepped care' models in which clients are initially offered the least intrusive form of intervention, have become part of the array of therapy formats used in healthcare systems. Further details on self-help learning packages and stepped care can be found in later sections of this chapter. As a means of supporting clients in using such interventions, some services have employed 'low-intensity' therapists (Shepherd and Rosairo 2008). These personnel usually have a background in psychology or a healthcare discipline and receive limited (less than 6 months) training in helping clients to make use of evidence-based self-help resources, typically based on CBT principles. Research has shown that while some clients value such support, other describe becoming frustrated because they believe that what they need is more intensive, expert care (Macdonald et al. 2007). Low-intensity support workers can be viewed as a subcategory within non-professional counselling. The distinctive features of low-intensity support are that it involves the delivery of a structured treatment protocol, and clients have the possibility to access more extended, intensive forms of therapy if they need it.

## Embedded counselling

Embedded counselling is the use of counselling skills and therapeutic principles and concepts by nurses, teachers, health workers, social workers, clergy, and others, whose primary professional role is not explicitly a psychotherapeutic one (Hoigaarda and Mathisen 2008; McLeod and McLeod 2011, 2015; Trygged 2012). There is a substantial literature on the ways in which brief interactions between such practitioners and their clients, patients, or service users may have the effect of alleviating anxiety and depression, promoting positive coping strategies, and enhancing well-being (McLeod and McLeod 2015). Although such episodes typically comprise brief empathic opportunities of around 10–15 minutes, some practitioners of embedded counselling, such as staff in care homes, may be able to engage in extended helping conversations over many years. Most embedded counselling is grounded in the flexible use of core counselling skills. However, some initiatives have involved training frontline practitioners in specific protocols around mental health help first aid (Bovopoulos et al. 2016) and suicide awareness and prevention. From the point of view of troubled individuals, the advantages of embedded counselling are that help is available at the moment of need and they

are able to make an informed choice around talking to someone with whom they may already have a shared history and trust. By contrast, seeing a professional counsellor or psychotherapist normally involves waiting, and being allocated to – or choosing – a therapist on the basis of little or no information about how they are as a person. The practice of embedded counselling requires training and skills, and organisational arrangements, around creating appropriate spaces for such conversations to occur, negotiation of appropriate means of confidentiality, referral systems for clients whose problem requires specialist assistance, and support or supervision for practitioners.

## Self-help groups

Counselling provided by non-professional therapists, low-intensity support workers, or embedded counsellors takes place within an ethical arena in which formal standards and systems (e.g. complaint procedures, vetting of workers) exist. The underlying meaning of these elements is that service users are in 'professional hands'. However, a great deal of counselling that occurs within contemporary society takes place in self-help groups that consist of people with similar problems who meet together without the assistance of a professional leader. The appeal of the self-help movement is reflected in two factors. The first is that self-help groups can be created in the absence of professional resources, and can thereby transcend the budgetary limitations of health and welfare agencies. The second is that people who participate in self-help groups appreciate the experience of talking to others who 'know what it feels like' to have a drink problem, to have lost a child in a road accident, or to be the carer of an infirm elderly parent.

The effectiveness of self-help groups for a variety of client groups has been well documented. For example, in the field of alcohol dependence there is evidence that Alcoholics Anonymous has an equivalent level of effectiveness as individual or group treatment provided by professional therapists (Ferri et al. 2006). Nevertheless, some mental health professionals remain sceptical about the value of self-help groups and view them as opportunities for socialising, or at best emotional support, rather than as arenas for serious therapeutic work (Salzer et al. 1999).

One of the issues that can lead to difficulties in self-help groups is the establishment of an unhelpful or inappropriate group culture. For example, the group may come to be dominated by one or two people who have covert intentions not to change, and who create groups where people collude with each other to remain agoraphobic, overweight, or problem drinkers. Another difficulty may be that the group does not evolve clear enough boundaries and norms, so that being in the group is experienced as risky rather than as a safe place to share feelings. Antze (1976) has suggested that the most effective self-help groups are those that develop and apply an explicit set of ground rules or an 'ideology'. Women's consciousness-raising groups, for example, can draw upon an extensive literature that details the philosophy and practice of feminist approaches to helping. Alcoholics Anonymous uses a clearly defined 'twelve-step' rulebook. Research by Davison et al. (2000) indicates the best attended self-help groups are based around conditions that are perceived by sufferers as stigmatising, for example Alzheimer's disease, alcoholism, AIDS, and breast and prostate cancer. In these conditions, participation in a self-help group can enable a person to develop a new self-narrative and sense of identity at a point of life crisis during which they feel that their previous identity has been irredeemably destroyed. A self-help group provides a person with multiple examples, or role models, of people who have come to terms with a painful or debilitating illness or condition, and can thereby operate as a source for hope, practical support, and coping strategies. Within the world of people who struggle with severe and enduring mental health difficulties, there exist a wealth of highly effective self-help groups, such as the Hearing Voices network (Romme and Escher 2000) and the global recovery movement (Davidson et al. 2005, 2006; Stricker 2000).

Apart from simply encouraging clients to make use of available self-help groups, and providing information where necessary, professional therapists are often involved in enabling self-help groups to get started, either through taking a proactive role within their organisation or because people in the group seek guidance about where to meet and how to proceed. For example, student counsellors

may encourage the formation of self-help groups among mature students or overseas students. Counsellors in hospitals can be involved in setting up and supporting self-help groups for nursing staff suffering from work stress or patients with cancer. The relationship between the 'expert' and the group requires sensitive handling, with the counsellor or psychotherapist being willing to act as external consultant rather than coming in and taking over.

## Peers

There are many examples of peer networks in which people function as counsellors or listeners for each other. Some of these networks are open to individuals from any background, as long as they have received some training in a specific peer counselling model. The most widely available examples of this approach can be found in re-evaluation co-counselling (Kauffman and New 2004) and the experiential focusing network (see, for example, <https://www.londonfocusing.com>). Each of these networks is based on the application of a broadly humanistic model that emphasises expression of here-and-now awareness of feelings and bodily states, with no 'expert' interpretation or guidance on the part of the person in the listening/helping role. Other peer counselling approaches bring together individuals with shared areas of experience, such as health workers, school students, or people with mental health difficulties, and provide them with a structured way of working constructively with each other (Boulton 2014; Cowie and Wallace 2000; Gillard et al. 2015; Rø et al. 2016). The advantages of peer counselling are that it can be easy to access, there is an absence of power imbalance, and participants have the opportunity to acquire helping skills and experience. For many people seeking help, it can be highly meaningful and supportive to have a chance to talk things through with someone who has first-hand experience of their situation.

## Therapeutic communities

A therapeutic community is a residential setting in which individuals seeking psychotherapeutic help live for a period of time and receive intensive therapy. Therapeutic communities reflect the ancient notion of the 'asylum' as a safe place, away from the pressures and threats of everyday life, in which a person may engage in a process of recovery and renewal, and make decisions around their life pathway. Because therapeutic communities are expensive to run, and require a substantial commitment on the part of the service user, they are generally organised around work with specific groups of clients with problems that have been shown to be hard to shift, such as addiction, long-term mental health difficulties, and personality disorder (Bloor et al. 1988; Kennard 1998; Lees and Manning 2003). Within a therapeutic community, it is expected that therapeutic interactions will take place between community members, as well as between staff and service users. The aim is to create a therapeutic culture or milieu in which all activities, including gardening, food preparation, and cleaning, may have therapeutic value. In terms of the question of 'who is the therapist?', a therapeutic community represents an extreme case – not only is everyone (professional therapists, domestic staff, and residents) a therapist, but the shared culture that is created together is also viewed as therapeutic.

## Who is the client?

Although counselling and psychotherapy are widely considered to focus on the needs and problems of individual persons, there are many effective therapy formats that involve working with couples, families, groups, and communities.

## Individuals

Most counselling and psychotherapy on offer, and most therapy theory and research, is focused on work with individual clients. This therapy format is so taken-for-granted that the important

contribution of therapy with more than one client is often overlooked. Individual therapy has many advantages. The practical advantages include the fact that it is much easier to arrange appointment times with one person than with a group of people. The therapeutic advantages include the possibility of facilitating insight and action that can be undertaken by the individual person on their own initiative. It is also easier to evaluate and monitor therapy outcome at the individual level, rather than at a couple, family, or group level.

There are some ways in which individual therapy can be unhelpful, however. At a cultural and societal level, one-to-one therapy both reflects and maintains an individualist rather than collectivist stance. While a focus on individual freedom and autonomy is a fundamental value of open democratic societies, it can also be viewed as having negative consequences in areas such as consumerism and erosion of social capital, and the individualisation of what in reality are social problems. For example, although many therapy services have been set up to support women who have been subjected to sexual violence, the existence and extent of such violence is a by-product of a sexist and patriarchal society. There are also times when an emotional or behavioural problem does not so much exist 'in' the individual, but arises instead from a pattern of interaction between members of a family or a cultural group. In such situations, therapy with an individual member of that family or group may have only a limited effect.

When conducting therapy with an individual client, it is essential to be aware that their presence and participation may be influenced by other people. Typically, a person will consult with others before entering therapy, or may even be advised or pressurised by others to seek therapy. The concept of 'autonomous motivation' relates to the extent to which a client chooses to attend therapy themselves (Mansour et al. 2012; Philips and Wennberg 2014; Zuroff et al. 2007). In the majority of cases, attending therapy is not a completely autonomous decision. Studies of autonomous motivation have shown that it is not a simple matter of one group of clients who have made up their own mind to attend, versus another, smaller group who are forced to attend because of a court order, for example. Zuroff et al. (2007) suggest that the implications for therapy of the process of decision-making to attend are so significant that it is valuable for a therapist to explore this issue in early sessions.

The difference between individual therapy and multi-person therapy can be highlighted by imagining what it is like for a client to talk about their feelings towards their mother (a) when talking to a therapist on a one-to-one basis, (b) when their spouse or partner is also in attendance (couple therapy), or (c) when their mother is also present (family therapy). Each of these contrasting scenarios invites different types of conversation and different therapeutic possibilities.

## Couples

People seek therapy as a couple because they recognise that their problems are rooted in their relationship rather than being attributable to individual issues. Counselling and psychotherapy agencies specifically devoted to working with couples or with individuals on relationship issues have become established in many countries. The field of couple therapy draws on ideas and methods from several therapy approaches, including psychodynamic (Crawley and Grant 2007), cognitive-behavioural (Epstein and Baucom 2002), emotion-focused (Greenberg and Goldman 2008; Johnson 2004), family therapy theory and practice (Bobes and Rothman 2002), person-centred (O'Leary 2011), and narrative (Percy 2007). Overviews of issues and methods in couple therapy are available in Harway (2005) and Gurman et al. (2015).

The presence in the therapy room of both partners brings a number of therapeutic processes into play that are not readily activated in one-to-one work. The communication patterns and style within the relationship can be directly observed, and different ways of relating can be tried out *in vivo*. For example, a simple but powerful technique used by most couple therapists is to help each member of the couple to listen while the other one is talking. The impact on the other, of statements or emotional states expressed by a partner, can be explored in the room. The couple may be able to construct a shared history of their relationship, make decisions together, and plan and carry



out homework tasks together. The aims of much couple therapy are to help the couple to achieve a shared understanding of what they want from each other and how they want to be together, and to clarify any boundaries between what information they share with each other and what they say to others outside their relationship. Each of these areas of joint exploration may have significant and wide-ranging implications for individual partners, in terms of how they feel about themselves and make sense of the trajectory of their own life.

This brief account of some of the main features of couple therapy does not do justice to what is a complex and thriving field of therapy practice. Instead, the aim has been to draw attention to some of the distinctive features of therapy with couples. The presence of both persons and the agreed focus on their relationship (the reason for seeking couple therapy in the first place) means that while couple therapy makes use of ideas and techniques from individual therapy, it represents a distinctive therapy format that allows a somewhat different type of learning to occur.

## Families

For most people who turn to counselling or psychotherapy for assistance with problems in living, the difficulties for which they are seeking help are connected, in some way or another, with their experience of family life. The family context is particularly striking when the client is a child or young person – in these cases it is all but impossible to disentangle the difficulties being faced by the individual child or adolescent from the web of family beliefs and relationships within which they live their life. For these reasons, one of the oldest established traditions of therapy practice has involved work with families rather than with individual clients. Family therapy presents a set of unique challenges and opportunities, and a rich array of theory and method has emerged from the field of family therapy. Further information and discussion around this mode of delivery of therapy can be found in Chapter 15.

## Groups

Group counselling and therapy is a major area of theory, research, and practice in its own right. The aim here is merely to identify some of the possibilities and issues arising from this mode of delivery of counselling help, rather than attempt a comprehensive review. Interested readers who wish to know more ought to consult some of the excellent introductory texts that have been published on the topic of group counselling (Brabender et al. 2004; Corey 2010; Corey et al. 2004; DeLucia-Waack et al. 2004; Jacobs et al. 2006; Paleg and Jongma 2005; Yalom 2005a), as well as background literature on theories of group dynamics (Poole and Hollingshead 2004). A fascinating insight into the process that can occur in a therapy group, and the experience of being a group therapist, can be found in the novel *The Schopenhauer Cure*, written by the celebrated group therapist Irvin Yalom (2005b).

There are several parallel historical sources of the origins of group therapy. Early forms of groupwork were pioneered by Jacob Moreno using psychodrama, by Kurt Lewin through the invention of 'T-groups', and by Wilfred Bion in his psychoanalytic groups. These various initiatives came together in the late 1940s and early 1950s to form what has become a strong tradition in the various branches of the helping professions. Group-based approaches are used in counselling, psychotherapy, social work, and organisational development. All of the main theoretical orientations in therapy have generated their own distinctive approaches to the theory and practice of working with groups.

Groups offer a number of ways of helping clients that are less readily available in individual therapy (Holmes and Kivlighan 2000). Specifically, a group provides an arena in which the client can exhibit a much broader range of interpersonal behaviour than could ever be directly observed in a one-to-one relationship with a therapist. One of the most fertile lines of research into group counselling and therapy has developed out of the work of Yalom (2005a) in identifying and defining the 'curative' or 'therapeutic' factors in groups. Struck by the complexity of what went on in his groups,



Yalom set about reviewing the literature with the aim of bringing together ideas about the factors or processes in groups that help people. He arrived at a set of 12 factors:

- group cohesiveness;
- instillation of hope;
- universality;
- catharsis;
- altruism;
- guidance;
- self-disclosure;
- feedback;
- self-understanding;
- identification;
- family re-enactment;
- existential awareness.

The presence of these factors in a group can be assessed by questionnaire or Q-sort (a kind of structured interview) techniques devised by Yalom and others. Bloch et al. (1981) have developed a similar approach based on asking group members at the end of each group session to write briefly about what they found helpful. The 'curative factors' research is of particular interest to many group facilitators because it is grounded in the perceptions of clients regarding what is helpful or otherwise, and because it provides valuable pointers to how the group might be run.

## Communities

Psychotherapeutic principles and methods can be applied also when working at a community level. The most fully developed examples of this kind of approach can be found in projects facilitated by narrative therapists in Palestine, with Aboriginal communities in Australia, and elsewhere (Denborough 2014, 2018). The aim of these initiatives is not to address issues such as depression, anxiety, trauma, and low self-esteem at an individual level, but rather to make it possible for the community to identify and make use of its own capacity for support, healing, and challenging both internal and external sources of oppression. From a narrative perspective, this process involves members of the community telling and sharing stories and accessing inspiring stories from other communities. Other ways of using counselling and psychotherapy methods at a community level are possible. For example, Verduin et al. (2014) report on a programme, initiated in the wake of the Rwandan genocide, that uses sociotherapy groups in communities as a means of re-building social capital.

Both narrative therapy projects and the work of Verduin et al. (2014) represent a combination of using the psychotherapeutic process to heal and come to terms with previous adversity, and to create support structures and resilience so that the community can move forward with greater confidence. The latter goal is similar in some respects to a long-established tradition of *preventative* interventions. For example, in relation to healthcare, the principle of prevention is espoused at a fundamental level by societies that have strict regulations relating to the purity of drinking water, standards for sewage treatment, and sell-by dates for food sold in shops – these are some of the basic preventative mechanisms used in the domain of public health.

Within the field of mental health, Caplan and Grunebaum (1967) identified three levels of prevention:

- 1 *Primary prevention*. Interventions intended to reduce the future incidence of a problem. Example: social education in schools with the aim of developing coping strategies and limiting future relationship and marital difficulties.

- 2 *Secondary prevention.* Targeting those at risk, or who have started to show early signs of a problem. Example: enriched induction and welcoming programmes in universities for international students who are at risk of 'culture shock' and adjustment stress.
- 3 *Tertiary prevention.* Interventions designed to minimise the negative impact of an existing disorder or problem. Example: counsellors attached to accident and emergency departments should make contact with, and follow up, individuals who present with signs of domestic abuse.

The concept of prevention has been largely neglected within counselling and psychotherapy. Over the years, keynote articles by leading figures such as Albee (1999), Romano and Hage (2000), and Hage et al. (2007) have drawn attention to (a) encouraging examples of good practice in prevention within the profession, and (b) the general lack of attention paid to prevention by the profession as a whole. When considering preventative programmes, it is essential to give careful consideration to the possible unintended consequences that can arise from meddling with 'natural' coping and support systems. For example, Stroebe et al. (2005) found that 'outreach' initiatives that made early contact with people who had been bereaved could be harmful (in contrast to services in which individuals troubled by their bereavement actively sought help, which they found to be generally quite effective). Rose et al. (2003) reviewed research into the effectiveness of critical incident stress debriefing for people who had undergone a traumatic event such as a car crash or armed robbery. The authors discovered that, although debriefing had been designed as a secondary prevention intervention, with the goal of identifying those at risk of developing PTSD, in many cases it worked in the opposite direction, increasing the likelihood of future PTSD. In both the bereavement and debriefing examples, it would appear that over-zealous early intervention by counsellors or psychologists may have had the effect of cutting across and undermining naturally occurring psychological mechanisms (e.g. avoiding thinking about what had happened) and social support networks (e.g. relying on family and loved ones).

An increasingly important form of prevention can be found in the brief training programmes, workshops, and support materials that have been developed in many countries for the purpose of enabling ordinary people to respond constructively to situations in which another person is exhibiting signs of stress, depression, or other mental health difficulties, or is suicidal (Dumesnil and Verger 2009; Kitchener and Jorm 2006). Typically, these programmes take an educational and public health approach to disseminating skills and knowledge that originate from counselling and psychotherapy practice and research.

## Technologies

The concept of technology can be used, broadly, to refer to any form of practical application of scientific knowledge. Almost 50 years ago, Hans Strupp, one of the pioneers of psychotherapy research, published an influential paper in which he argued that the core technology of psychotherapy was the interpersonal power and influence of the therapist (Strupp 1972). Even at that time, other aspects of the technology of psychotherapy could be identified, such as the use of projective techniques in assessment and encouraging clients to read relevant self-help books and novels. More recently, further technologies have been integrated into the process of therapy – the telephone, various internet applications, audio- or video-recording of sessions for supervision and training, brief client self-report measures to track progress in therapy, and medication.

## Telephone

In terms of numbers of client contacts made each year, telephone counselling services provide more counselling than any other type of counselling or psychotherapy agency. Telephone counselling has been around for a long time and there is substantial research evidence of its effectiveness (Brenes et al. 2011; Lester 2012; Rosenfield 2013), even with clients who would prefer face-to-face contact

with a therapist (Bee et al. 2010). There are examples of the successful use of telephone counselling and psychotherapy for a wide range of presenting issues.

In a particularly well-designed study of the effectiveness of telephone counselling, Reese et al. (2002, 2006) conducted a survey of client experiences around receiving telephone counselling from an employee assistance programme. Eighty per cent of clients reported that the specific problem that led them to counselling had improved, with 68 per cent being 'very satisfied' or 'completely satisfied' with the telephone counselling they had received. Clients whose original problem was most severe were helped less than those whose original problem was less severe. Of the 236 participants who responded to the survey, 96 per cent were willing to seek telephone counselling again (compared with 63 per cent who were willing to seek face-to-face counselling again). Of those who had received both telephone and face-to-face counselling, 58 per cent preferred counselling by telephone. Moreover, telephone counsellors were perceived as expert and trustworthy, and clients reported developing a strong bond with their counsellor. Reese et al. (2006) analysed clients' perceptions of the value of telephone counselling and three main factors emerged: *control* (e.g. 'I felt I could hang up if I did not like it'; 'I liked that the counsellor could not see me'); *convenience* ('I liked that I could call when I wanted to'), and absence of *inhibiting* influences (e.g. 'I liked that telephone counselling was free').

There are important differences between the process of telephone counselling and face-to-face work. Lester (2012) suggests that telephone counselling encourages the positive transference felt by the caller. The faceless helper is readily perceived as an 'ideal', and can be imagined to be anything or anyone the caller needs or wants. Grumet (1979) highlights the elements of the telephone interview that contribute to increased intimacy: visual privacy, the speaker's lips being, in a sense, only inches from the listener's ear, and a high level of control over the process. A fascinating case study by an experienced psychoanalyst (Anonymous 2011) vividly describes the intensity and intimacy of telephone sessions with her own analyst.

There are specific training needs associated with telephone counselling (Rosenfield 2013). Telephone counsellors need to work quickly, to be flexible and intuitive, and to be able to cope with silence. Hoax calls and sex calls draw on skills that are less frequently used in face-to-face counselling. Telephone counsellors are required to enter into the personal worlds of people actually in the middle of crisis, and are therefore exposed to strong emotions. They may become remote participants in suicide. Not only are telephone counsellors involved in a potentially raw and harrowing type of work, they are also less liable to receive feedback on the results of their efforts. Indeed, they may never know whether a caller did commit suicide or did escape from an abusive family environment. The rate of turnover and burnout in telephone counselling agencies, and the provision of adequate support and supervision, are crucial topics for consideration. There are also ethical issues around being able to respond to client risk of harm to self and others, and knowing whether the caller is capable of giving consent for treatment.

From the point of view of the caller or client, telephone counselling and psychotherapy has two major advantages over face-to-face therapy: access and control. It is easier to pick up a phone and speak directly to a counsellor than it is to make an appointment to visit a counselling agency some time next week. Telephone counselling therefore has an important preventative function in offering a service to people who would not submit to applying for other forms of help, or whose difficulties have not reached an advanced stage. Many people are ambivalent about seeking help for psychological problems: the telephone puts them in a position of power and control, able to make contact and then terminate when they want to.

## Internet

The fastest growing mode of delivery of counselling and psychotherapy within the past two decades has been via the internet. On-line systems are widely used in the organisation and management of therapy services, for example in advertising, making appointments, sending reminders, storing client records, administering feedback measures, supervision, training, and invoicing. In addition,

many different forms of internet technology have been developed for the delivery of therapy. The main types of psychotherapeutic on-line and tele-health interventions are outlined below.

Valuable sources of information about trends and issues in the use of the internet in therapy can be found in Barnett and Kolmes (2016) and Brenes et al. (2011). Reviews of research on the effectiveness of such interventions are available in Menon et al. (2017), Shingleton et al. (2013), and Stefanopoulou et al. (2018). On the whole, research has shown that internet therapy is broadly equivalent in effectiveness to face-to-face therapy, and that specific internet tools (e.g. apps) can enhance the effectiveness of regular therapy. However, it is important to be cautious about these findings, because they are based mainly on studies in which individuals have opted to take part in on-line therapy: some clients would not find internet-mediated therapy acceptable, and thus would not agree to take part in research using that mode of intervention.

*Email counselling and psychotherapy.* There are two main means of conducting individual therapy over the internet: asynchronous (time-delayed) communication between therapist and client, and various types of synchronous contact in real time. Murphy and Mitchell (1998) have outlined some of the advantages of email therapy:

- There is a permanent record of the whole of the therapy contact (this can be useful for the client, the therapist, and the therapist's supervisor).
- Typing is an effective means of 'externalising' a problem.
- The act of writing helps the person to reflect on their experience.
- Power imbalances are reduced – the internet is an intensely egalitarian medium.
- The client can express their feelings in the 'now' – they can write email messages when in the middle of a depression or panic attack, rather than waiting for the next therapy session to come around.

There are a number of clinical, practical, and ethical issues associated with on-line counselling and psychotherapy. For example, therapists find it difficult to assess the suitability of a client, or to take action if the client exhibits risk of harm to self or other, or is upset at the end of a session. Similarly, it is difficult for clients to assess the professional status and qualifications of the therapist, or to make a complaint if a breach of confidentiality or other ethical issue arises. Given the amount of hacking and lost data that is reported on the internet, it can be a challenge to ensure the security and confidentiality of written material: what happens if an email goes astray, or a stranger enters a chat room? How secure are encryption systems? It can be hard to maintain contact if the internet link is broken. There are professional issues associated with providing therapy to a client in a different country (or state in the USA) that does not recognise one's therapy qualifications or competence. An important line of research has looked at the characteristics of clients who prefer email therapy. In one study, Kurioka et al. (2001) examined the acceptability and use of email counselling for employees in a Japanese manufacturing company. The employees were offered health counselling by email, telephone, ordinary mail, or face-to-face contact. Email counselling was particularly popular with younger employees, and with those who had mental health issues and were concerned about the shame and stigma associated with visiting a therapist's office.

*Communication by video link.* In rural or island communities where clients may need to travel considerable distances to see a therapist, video-conferencing can be used to deliver treatment (Simpson 2003). Such services are also suitable for clients who find it hard to travel, either because of age, disability, or being a full-time carer.

*Computer-based and on-line assessment.* Questionnaires and other scales that are used for assessment purposes can be delivered on-screen, rather than through a traditional paper-and-pencil format (Emmelkamp 2005).

*On-line therapy sites.* A number of initiatives have constructed websites designed to deliver therapy on-line, usually informed by CBT principles. One widely used self-help package is *Beating the Blues*, which comprises a structured course of CBT treatment for depression, and is licensed to general practitioners and family physicians for use in their surgeries. It includes innovative use of characterisation (stories of people who have struggled to overcome depression), alongside more conventional self-help exercises. A detailed account of the thinking that informed the design of *Beating the Blues* is available in Cavanagh et al. (2003). A series of studies have established the effectiveness of *Beating the Blues* as an intervention for mild and moderate levels of depression (Cavanagh and Shapiro 2004; Cavanagh et al. 2006; Grime 2004; McCrone et al. 2004; Proudfoot et al. 2004). A similar package, developed for use in anxiety, is *FearFighter* (Gega et al. 2004; Schneider et al. 2005). Both *Beating the Blues* and *FearFighter* were approved by the UK National Institute for Health and Care Excellence as effective treatments. The *moodgym* site (<https://moodgym.com.au/>), by contrast, consists of an eclectic blend of self-help exercises intended to promote psychological well-being as well as enable users to deal with problems. In addition to sites such as *Beating the Blues* and *FearFighter* that are only accessible through health profession gatekeepers, there are also many other sites that are accessible to anyone with an internet connection: a survey conducted by Anderson et al. (2004) reported that some anxiety-information sites were then receiving six million hits each month!

*Text messaging.* Compared with email therapy, mobile phone texting allows a therapist and client to keep in touch on a more frequent basis between therapy sessions. For young people, this is also a form of help that is consistent with a favoured mode of communication (Gibson and Cartwright 2014b).

*Apps.* There are thousands of mental health apps that can be used to supplement the process of therapy. For example, *Mood 24/7* (<https://www.mood247.com>) is a tool that allows individuals to rate their mood on a regular basis throughout the day. They can then use this information, with the help of their therapist, to identify those situations that trigger either low mood or positive well-being. A substantial amount of research has shown that clients find it helpful to use apps (Lindhjem et al. 2015; Lui et al. 2017).

*Chat rooms.* Chat rooms are on-line sites where people can communicate with each other around specific problems (Dowling and Rickwood 2014). Some sites include the involvement of a counsellor as a resource or monitor. Golkaramnay et al. (2007) reported on a project in which clients who had received time-limited group therapy were offered ongoing support and contact through an internet chat room. They found that, at one-year follow-up, significantly fewer clients in the chat room condition were assessed as poor outcome cases, compared with clients who had received group therapy alone.

*Virtual reality.* Several projects have involved the development of virtual reality environments for therapeutic purposes, such as around therapy for panic attacks and anxiety (Hartanto et al. 2014; Kampmann et al. 2016). If a sufficiently realistic virtual world can be created, in which the client can experience different levels of severity of their problem, it makes it possible for the therapist to directly coach them in the use of coping strategies in a way that would be hard to replicate in the real world.

*Avatars.* It is possible to use a computer gaming environment to allow the client to create imagined selves (avatars) through which they can work with a therapist to externalise and express different aspects of self in ways that allow reflection, insight, and decision-making to occur (Rehm et al. 2016; van Rijn et al. 2017, 2018).

Taken as a whole, the use of on-line formats for therapy has enormous potential and an even wider range of on-line therapeutic methods will surely emerge in the future. There are three main



advantages associated with such formats. The first concerns cost and accessibility – internet therapy has the potential to reach people who, for one reason or another, find it hard to attend therapy in an office. The second is flexibility – for example, being able to consult a therapist or make mood ratings at any time or place. The third is client preference – increasingly, people are comfortable with electronic media and are open to finding new ways to use it to enhance their lives. The main disadvantage of internet therapy is that it cannot provide the experience of being physically and bodily present with another person in the moment.

## Self-help materials

Reading a book (or the equivalent on a screen) is a format that many people choose as a means of dealing with their emotional and behavioural problems in living. Self-help reading (sometimes referred to as bibliotherapy) can be undertaken in the absence of any kind of relationship with a professional therapist, or can be used to supplement the work that happens in therapy sessions. Psychotherapeutic concepts and methods have become widely packaged and marketed in the form of books, websites, and videos. These activities can be viewed as reflecting the ‘active client’ stance of Bohart and Tallman (1999): the effectiveness of any type of therapy relies on the person’s capacity for self-healing. There are also people who are wary of professional helpers, and who prefer to sort out their difficulties alone or through learning about the experiences of others who faced the same challenges. Furthermore, the aim of governments and health service providers is to deliver therapy at minimal cost.

There has been an explosion of interest in recent years in the potential role of self-help books in counselling and psychotherapy (Norcross 2006a), reflected in a massive public appetite for learning about psychological and psychotherapeutic topics (McGee 2005; Menchola et al. 2007). There are three main categories of book that are used in bibliotherapy. The first category consists of explicit self-help manuals, which are designed to enable people to understand and resolve a particular difficulty in their lives. Self-help books usually contain exercises and suggestions for action, and are typically grounded in a cognitive-behavioural theoretical orientation. However, the remarkable *Barefoot Psychoanalyst* by Rosemary Southgate and John Randall (1978) demonstrates that it is possible to employ even Kleinian and Reichian ideas in a self-help booklet. Examples of widely used self-help mental health books include:

Brown, B. (2015) *Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead*.

Burns, D. D. (2000) *The Feeling Good Handbook*.

Fennell, M. (2016) *Overcoming Low Self-Esteem: A Self-Help Guide Using Cognitive-Behavioural Techniques*.

Greenberger, D. and Padesky, C. A. (2015) *Mind Over Mood: Change How You Feel by Changing the Way You Think*.

Ingham, C. (2016) *Panic Attacks: What They Are, Why They Happen, and What You Can Do About Them*.

Jeffers, S. (2007) *Feel the Fear and Do It Anyway: How to Turn Your Fear and Indecision into Confidence and Action*.

Mason, P. T. and Kreger, R. (2010) *Stop Walking on Eggshells: Taking Your Life Back When Someone You Care About Has Borderline Personality Disorder*.

McBride, K. (2008) *Will I Ever Be Good Enough? Healing the Daughters of Narcissistic Mothers*.

Rowe, D. (2003) *Depression: The Way Out of Your Prison*.

Williams, M., Teasdale, J., Segal, Z. and Kabat-Zinn, J. (2007) *The Mindful Way through Depression: Freeing Yourself from Chronic Unhappiness*.



An increasingly popular genre within this literature comprises picture books and comic books, such as *I Had a Black Dog* (Johnstone 2007) and *Are You My Mother? A Comic Drama* (Bechdel 2012).

Self-help reading resources can also take the form of texts that essentially discuss ideas and experiences rather than being explicitly oriented towards behaviour change. These may originally have been written for a professional audience, but become taken up by the general public or achieve 'cult' status. Examples include: *The Road Less Traveled* by Scott Peck (1978) and Alice Miller's (1987) *The Drama of Being a Child*. In addition to self-help books distributed by commercial publishing houses, there is an array of pamphlets, leaflets, and workbooks produced by individual therapists and counselling agencies.

A further category of bibliotherapy texts comprises autobiographical and biographical works by people who have experienced specific mental health problems. Individuals who are troubled by such mental health problems may often gain a great deal of support, insight, and hope by being able to identify with the lives and feelings of others who have faced similar challenges. Examples of influential texts in this category are *An Unquiet Mind* by Kay Jamison (1995), which describes the experience of mood disorder, *Elegy for Iris* by John Bayley (2001), which recounts the experience of caring for a spouse suffering from Alzheimer's disease, and *A Man Named Dave* by Dave Pelzer (2004), which is about surviving child abuse. An overview of the issues involved in using autobiography in psychotherapy can be found in Sommer (2003).

The final category of bibliotherapy works consists of fictional texts, such as novels that depict life stories, behavioural patterns, choices, and coping strategies that may be relevant to those undergoing therapy. Examples include *The Bell Jar* by Sylvia Plath (1963) and *The Trick is to Keep Breathing* by Janice Galloway (1989).

Although there is a wealth of self-help materials readily available in the public domain through libraries and bookshops, there are challenges for counsellors and psychotherapists who wish to make use of this type of resource. For example, while theory and research in counselling emphasise the importance of the therapeutic relationship, in self-help reading such a relationship is entirely absent. Self-help manuals also assume that the same techniques will be effective for all people who experience a particular problem, rather than individualising the intervention for each client. Guidelines for integrating self-help into counselling have been prepared by Fuhrman et al. (1989), Campbell and Smith (2003), and Norcross (2006a). They suggest that therapists seeking to capitalise on self-help resources should:

- familiarise themselves with relevant self-help books, in advance of recommending them to clients;
- offer tangible support and encouragement to clients using self-help materials;
- tailor their recommendations to the needs of the individual client;
- pay attention to reading level and interests;
- as far as possible, use self-help texts that are backed up by research evidence;
- consider the relevance of the self-help book to the phase of therapy that the client has reached;
- guard against intellectual discussion of a self-help book as a diversion from the therapy.

However, many people make use of self-help books without ever consulting a professional counsellor or psychotherapist. It is likely, therefore, that at least some clients may prefer that their therapist abstains from asking them to discuss the books they have been reading – they may wish to retain their reading as a private, independent therapeutic strategy.

A number of qualitative studies, based on interviews with clients, make a valuable contribution to understanding how and why self-reading is helpful (Bruneau et al. 2010; Levitt et al. 2009; Mårtensson and Andersson 2015; Pettersson 2018; Salmenniemi and Vorona 2014). What emerges from these studies is that it is essential for the reader to be able to identify with the author, and to immerse themselves in the text. In this way, different readers make use of the material they encounter in

different ways, depending on their own individual needs and interests. Evidence of marked individual differences in attitudes to self-help reading was also found in a quantitative survey carried out by Wilson and Cash (2000). Some studies have suggested that gender is a key element in the ways in which readers respond to self-help books – there appear to be significant differences between books that appeal to men and those that are meaningful for women (McLean and Kapell 2015). From a critical perspective, Ehrenreich (2009) and Hazleden (2010) have argued that the underlying message of many self-help books reinforces an individualist philosophy of self-entitlement that may in the long run be damaging both to individuals and society.

Systematic reviews of the effectiveness of self-help reading (Cuijpers et al. 2010; den Boer et al. 2005; Gualano et al. 2017; Hirai and Clum 2006; Main and Scogin 2003; Menchola et al. 2007) have consistently found convincing evidence that self-help reading is moderately helpful for the majority of people, across a wide range of presenting difficulties. However, self-help was found to be less effective than treatment by a counsellor or therapist, or ‘guided self-help’ in which minimal contact was provided from a helper who supported and encouraged the client in their use of self-help materials.

Although there is supporting research evidence for the use of self-help reading, it is nevertheless important to be aware that the value of self-help depends to a great extent on the context in which it is used. The most encouraging evidence for the effectiveness of self-help reading comes from studies using volunteer participants, who have actively sought self-help resources. By contrast, two well-controlled studies carried out within the NHS in the UK, in which patients had wanted face-to-face personal care, reported less positive results. In studies in which participants were allocated to a self-help condition, both Mead et al. (2006) and Salkovskis et al. (2006) found that NHS patients were resistant to taking up the offer of self-help care, often did not make active use of the texts that were provided, and showed only marginal improvement in symptoms compared with control patients who had not received self-help workbooks, even when the workbook was individually tailored to their needs (Salkovskis et al. 2006) or their use of the materials was facilitated by a mental health worker (Mead et al. 2006). The results of these studies suggest that the *meaning* of self-help reading may be intrinsic to its helpfulness. People who actively seek out self-books from their library or bookshop, or are encouraged to read such books by their therapist, may benefit from the fact that their sense of agency or self-efficacy is being reinforced through their reading (Bohart and Tallman 1999). By contrast, those who are offered ‘institutionalised’ self-help materials in the absence of more desirable and credible treatments, may take the view that they are being ‘fobbed off’ with a form of help that is second best and principally driven by a desire to cut costs.

### Box 31.2: The diversity of sources of self-help

The use of self-help activities has received a great deal of attention within the counselling and psychotherapy professions because they represent a potentially cost-effective and accessible mode of delivery of therapeutic learning and care. Thus, it may be useful to place these developments within a broader cultural perspective. A central characteristic of any culture is that it provides a range of self-care remedies that people learn to employ in order to deal with everyday distress and discomfort. The organisation of such self-care strategies in contemporary society is illustrated by a survey carried out by Jorm et al. (2004) with members of the public in Australia. Participants in the survey were asked to complete a brief depression scale and a questionnaire inviting them to indicate their current use of a range of self-help sources. The results of the survey showed that a very wide set of self-care or self-help procedures were used by individuals reporting low or mild depression. For example, the following actions were regularly used by more than 10 per cent of those with mild depression: aromatherapy, avoiding caffeine, being with pets, cutting out alcohol, exercise, vitamins, dance, self-help books, and meditation. Jorm et al. also

found three distinct ‘waves of action’ associated with psychological distress. In the first wave, individuals with mild problems draw upon strategies that are already in everyday use, such as exercise, music, and interaction with family and friends. As distress becomes more severe, the use of these everyday strategies declines, as individuals search for specific remedies, such as self-help books and complementary therapies. Finally, if the problem becomes even more troubling, the person seeks professional help. Self-help books, groups, and websites can be viewed as belonging to a broad category of ‘cultural resources’ (McLeod 2005) that can be used therapeutically by individuals in a variety of ways, depending on the severity of their problems.

## Combining formats

The existence of multiple formats within which psychotherapeutic help can be provided, inevitably leads to the question of whether, and under what conditions, they can be combined. This is not a question that has received much research interest. However, three broad strategies can be identified: ‘adding on’ (adjunctive interventions); ‘assembling’ a package such as a treatment programme or therapeutic community; and ‘stepped care’, in which a therapeutic pathway is constructed that begins with the least intensive, intrusive, or costly format, and offers a structure that ratchets up to more demanding formats.

## Adjunctive interventions

Adjunctive therapeutic interventions or activities are when a client undertakes another form of help alongside their main therapy. A good example can be found in a study by Wong et al. (2018), in which participants received normal face-to-face therapy and then were offered the option of carrying out some structured expressive writing tasks (gratitude letters) between sessions. Other types of adjunctive therapy include attending yoga, an art class, or a gym between sessions. If such activities are brought into the main therapy session itself, the resulting approach would most likely be described as some form of integrative therapy. However, from the perspective of the client, an activity suggested by the therapist, that they pursue between sessions, is integrative in the context of what therapy means to them. Although adjunctive therapeutic activities are likely widely used, in an improvised informal way, it is not known how frequently, how helpful it is, or what the pitfalls might be.

## Programmes and communities

Some counselling and psychotherapy services are organised around planned packages that incorporate different formats. Some of these approaches are described as ‘programmes’ that clients can enter or sign up for, while others are offered within ‘therapeutic communities’ that are usually residential. Typically, such multi-format models are used with clients who have severe, complex, or life-threatening problems such as eating disorders, addictions, or personality disorders.

## Stepped care

The concept of *stepped care* refers to a model for organising the delivery of healthcare, in which the client or patient is first of all offered the least intensive form of potentially effective intervention, and only offered more complex or intensive interventions if the ‘frontline’ or ‘gateway’ treatment proves to be ineffective (Haaga 2000). The principle of stepped care is widely accepted within the mental health professional community in the UK and other countries. For example, in the UK, the National Institute for Health and Care Excellence supports a stepped care approach for mental health problems. In principle, stepped care can involve a wide variety of different treatments. However, in practice, not all treatments are likely to be available or affordable in one locality; the

real-world stepped care systems that have been developed tend to be based on some variant of the following structure:

- Step 1:** access to self-care materials, such as books, manuals, leaflets, and websites;
- Step 2:** counselling or time-limited psychotherapy of a generic nature;
- Step 3:** long-term, specialist psychotherapy focused on a specific disorder, often based on a manualised, empirically validated form of treatment;
- Step 4:** inpatient hospital treatment, involving medication supervised by a psychiatrist.

Typically, Steps 2 and 3 may be accompanied by a prescription for medication, such as antidepressants, prescribed by a GP or family doctor.

Stepped care is an attractive option for policy-makers and service managers, because it helps to address the challenge of enabling large-scale access to psychological care without the need to employ many more professional therapists. Essentially, stepped care offers low-intensity therapy (e.g. guided self-help, delivered by a minimally trained paraprofessional) to large numbers of patients, while retaining more expensive, specialist forms of help for those who are most in need.

Despite the inherent logic of stepped care mental health/psychotherapy systems, there are formidable difficulties involved in successfully meshing together different elements of an integrated system. For example, a survey of the use of stepped care in IAPT services for patients with anxiety and depression in NHS England (Richards et al. 2012) found marked differences in success across local services operating stepped care systems. The issues involved in implementing stepped care are discussed by Bower and Gilbody (2005) and include:

- Developing robust methods of assessment to ensure that each ‘step-up’ occurs at the right time for each client.
- Identifying client groups for whom stepped care is appropriate. For example, Bower and Gilbody (2005) argue that, within the field of eating disorders, stepped care may be more suitable for binge eating, where ‘failure’ at the initial step may have relatively minor consequences, compared with anorexia, where early treatment failure may have life-threatening implications.
- Assessing the acceptability of stepped care for both service users and health professionals, many of whom may regard immediate access to a fully qualified, specialist counsellor or psychotherapist as a basic right.

The most thorough trial of stepped care that has been published comprised a study carried out in Santiago, Chile, in which low-income depressed women were provided with either treatment as usual from a primary care doctor, or with a psycho-educational group experience (Step 1) followed by medication if necessary (Step 2) (Araya et al. 2006). The results showed that, compared with usual care, the stepped care package was significantly more effective and only marginally more expensive. It is important to be clear about the meaning of this study. The women who received stepped care were given much *more* care than those who received normal treatment – three additional group-workers were employed for the duration of the project. However, these additional costs could be set against savings arising from reduced medication costs. It is essential to interpret the findings of this study with caution – this was a single piece of research, carried out within an environment of urban poverty in which alternative health resources were scarce. Nevertheless, it does suggest that it may be possible to utilise carefully designed stepped care packages to enhance the quality and effectiveness of treatment in depression. A review of the effectiveness of stepped care for depression in adults found evidence that such an approach could be more effective than usual care, but that few good-quality studies had been carried out (Firth et al. 2015).

Some research has explored the experience of stepped care from the point of view of clients and therapists. Macdonald et al. (2007) interviewed clients about their experience of the first step (guided self-help) in a stepped care system in the UK. Although some clients reported that the help

they had been offered had been helpful, on the whole there was a lot of dissatisfaction with the approach. No other studies of client experiences of stepped care appear to have been carried out. Interviews with clinicians (doctors and psychologists) working in a stepped care programme in the Netherlands found that while these practitioners realised the potential value of the system, they reported that it was difficult to make it work in practice because of the extra effort involved in assessing and monitoring clients and making onward referrals (Franx et al. 2012; Hermens et al. 2014). Confirmation of these themes is available in a study by Delgadillo et al. (2015), in which therapists working in a stepped care scheme in the UK described themselves as using personal and subjective criteria around whether to keep a client or refer them on, rather than adhering to the formal stepped care protocol.

## Conclusions

This review of alternative modes of providing psychotherapeutic help for people in need indicates that a wide array of therapeutic formats is available. It is important to acknowledge that the list of formats covered in the present chapter is not comprehensive – valuable formats such as art-making and writing are discussed in other chapters. The variety of modes of delivery of therapy is expanding year-on-year, as new technologies become available and therapists creatively devise new ways of working. There is therefore plenty of scope for therapists and therapy organisations to experiment in their use of therapeutic resources and modalities – it is clear that face-to-face individual therapy is only one among many possible ways of providing a therapeutic experience. Moreover, it would appear that the approaches described in this chapter have the potential to reach people who might be reluctant to seek out conventional one-to-one counselling or psychotherapy. For example, email and internet-based services give greater anonymity and control to clients who may be fearful or ashamed about engaging with therapy. One of the key implications of the material discussed in the present chapter is that therapeutic ‘monocultures’, in which clients are only offered one type of therapy experience, are neither helpful nor justifiable.

The diversity of therapeutic formats has important implications for therapist training and development. Each of the modes of delivery discussed in this chapter requires training, based in an acknowledgement that they demand specific skills and knowledge on the part of practitioners. Therapists may have more of an aptitude for working in one modality than another – it may be that one of the best ways to produce competent therapists is to help them to find the format(s) within which they can do their best work.



### Topics for reflection and discussion

- 1 Reflect on the work of a face-to-face counselling or psychotherapy agency with which you are familiar. In what ways could the service offered by that agency be enhanced by introducing some of the other modes of delivery discussed in this chapter?
- 2 Do different modes of therapy (e.g. groups, bibliotherapy, telephone counselling, individual face-to-face work) produce different outcomes in clients? Is the learning process for clients the same whatever type of intervention is used or are there change elements unique to each format?
- 3 Discuss the extent to which alternatives to traditional individual therapy represent attempts to deal with issues of power and control in the helper–helped relationship. How successful are these alternative approaches in empowering clients?

- 4 You have been asked to run a training course intended to enable counsellors who work with individual clients in face-to-face settings to undertake telephone counselling, groupwork, or couple therapy. What would you include in the course? If you have been trained in standard one-to-one therapy, what skills and knowledge do you believe you need to acquire to work competently in one of these other formats?
- 5 Reflect on the experience of reading a self-help book, preferably one that you consulted some time ago. Why did you decide to read the book? Did you discuss it with anyone else, or merely work through it on your own? What impact, either in the short term or of a more lasting nature, has the book made on you? What was it about the book that you felt was most and least helpful?
- 6 Do alternative formats and modes of delivery present new ethical dilemmas? What might these be and how might they be addressed?
- 7 Are there particular formats or modes of delivery that are likely to be more attractive to or appropriate for men and women?
- 8 Are there particular formats or modes of delivery that are likely to be more attractive to or appropriate for individuals from particular demographic groups (e.g. older people, millennials) or cultural backgrounds?
- 9 What is your own preferred mode of delivery of therapy? In terms of developing your career as a therapist, which modes of delivery are most likely to capitalise on your personal skills and interests?

## Suggested further reading

This chapter deals with a diverse set of topics and readers interested in learning more are recommended to follow up sources referenced in specific sections of the chapter. It is perhaps worth noting that at present there does not seem to be any unified model, or research literature, that addresses the advantages and disadvantages of the different modes of delivering therapy.



# Chapter 32

## Looking ahead: future challenges for the psychotherapeutic professions

<b>Introduction</b>	<b>524</b>
<b>Challenges within the world of counselling and psychotherapy</b>	<b>525</b>
<b>The future of counselling and psychotherapy as professions</b>	<b>526</b>
<b>Challenges in the relationship between therapy and society</b>	<b>528</b>
Facing up to cultural difference	528
New technologies, new types of person	529
Environmental collapse	529
The crisis within democratic processes and institutions	529
<b>Conclusions</b>	<b>530</b>
<b>Topics for reflection and discussion</b>	<b>531</b>
<b>Suggested further reading</b>	<b>531</b>

### Introduction

One of the main aims of this book has been to offer an appreciation of how making sense of contemporary issues in counselling and psychotherapy requires an understanding of where these issues have come from – their social and historical context. Strategies used in society to cope with emotional and interpersonal problems in living are significantly different now compared with what was available to our grandparents or great-grandparents. Therapy in modern industrial societies is significantly different from equivalent healing practices in traditional cultures. The intention of the present chapter is to extend this social and historical perspective into the future. What are the implications for counsellors, psychotherapists, and service users of trends that can already be identified? How is therapy likely to change over the next 10 or 20 years?

These questions are important for anyone who is a therapist, or is in training to become a therapist, because they represent emerging challenges to which they will almost certainly need to adapt

over the course of their career. They are also important questions for clients and service users. Therapy, like any social institution, is partly devoted to fighting the wars of the past, partly engaged with current issues, and only to a very limited extent oriented towards dealing with new types of problem that are emerging over the horizon. For people whose difficulties are in the third category, it may be that therapy theory and practice has not sufficiently caught up with their needs and experiences.

This chapter is organised in three main sections. First, the internal evolution of counselling and psychotherapy is discussed. Next, these themes are considered in the context of a broader analysis of the future of professions within modern industrial-technological societies. The final section explores some of the possible ways in which environmental and technological shifts may result in major changes to therapy theory and practice.

## Challenges within the world of counselling and psychotherapy

From time to time, surveys are carried out among leading academics and researchers to find out what they believe are the main challenges facing counselling and psychotherapy, and how they anticipate therapy theory and practice might need to adapt in response to these challenges. One such survey found that leading experts observed an increasing pace of change within the world of therapy, in the form of an anticipated future ‘half-life’ of professional knowledge (the time within which current knowledge would need to be updated) of around seven years (Neimeyer et al. 2012, 2014). A similar survey carried out by Norcross et al. (2013) reported a consensus around the likelihood that a wider range of methods would be more widely used over the next decade: on-line self-help therapies, smartphone applications, therapist recommendation of self-help resources, virtual reality, social networking interventions. Contributors to this survey believed that in the future a greater percentage of psychotherapy would be offered by telephone and video-conferencing, and that evidence-based guidelines would become a standard part of routine therapy. They also suggested that mindfulness-based therapies, CBT, and integrative therapy would increase in importance, while other established therapies would remain the same or decline in importance. In relation to future developments anticipated by counselling psychologists in the USA, Taylor et al. (2018) found that the main shifts were believed to be in the direction of greater attention to diversity (e.g. culturally-adapted therapy), social justice, and activism, as well as issues around professional competence.

Each of the above surveys was carried out in the USA and sampled the opinions of senior therapists. It is likely that surveys of younger therapists, practitioners in other parts of the world, or service users would reveal some different projections. In terms of themes and trends discussed in the present book, a number of additional professional challenges can be identified:

- replacing diagnostic categories derived from medicine and psychiatry with an alternative system for classifying and categorising cases and presenting problems;
- moving beyond the fragmentation arising from distinct ‘schools’ of therapy, and finding some means of harnessing ideas and interventions from across the spectrum of therapies;
- responding effectively, through strategies for shared decision-making, to client preferences and choices;
- doing research that has the potential to inform practice, and devising training and supervision systems that make it possible for therapists to harness scientific knowledge for the good of clients;
- ensuring that the best is not the enemy of the good – achieving a balance between the provision of highly specialised but costly therapies for specific disorders, and access to generic, frontline community-based services.

What is beyond doubt is that things will not stay the same. Findings from a range of sources suggest, with differing emphases, that therapists will be called upon to acquire substantial new skills and knowledge at regular points over the course of their career.

## The future of counselling and psychotherapy as professions

The ideas and future projections outlined in the previous section are predicated on the assumption that they will unfold within existing organisational and professional structures. However, this assumption may not hold. It is possible that what we know as a 'profession' may itself be entering a period of rapid change.

The concept of 'professionalism' is widely used in our culture in a variety of ways. An individual who is deemed to operate in a 'professional' manner is assumed to be trustworthy, knowledgeable, and to possess specific expertise. Another meaning refers to the ways in which different occupational groups are considered to have a special status in society. So, for instance, medicine, nursing, law, the ministry, architecture, teaching, social work, and accountancy are recognised by the state as autonomous professions that have the right to practise in particular areas of knowledge, and to exclude from practice those who have not been credentialed by the relevant professional body. Within society, membership of a 'profession' is associated with access to relatively well-paid, secure employment.

The status of counselling and psychotherapy as autonomous professions, separate from cognate groups such as psychiatry, social work, education, and the clergy, has always been a sensitive issue. Each of these professions undertakes tasks or functions that overlap with counselling and psychotherapy, in some instances substantially so.

In *The Future of the Professions: How Technology Will Transform the Work of Human Experts*, Susskind and Susskind (2015) bring a new perspective to bear on this issue. They begin by looking at the history of the professions and the pathways to state recognition followed by existing professions, but then look forward to examine trends and potential future developments within the law, teaching, medicine, architecture, journalism, accountancy, and management consulting. Although they do not explicitly discuss the professions of counselling, psychotherapy and psychology, their analysis has important implications for these occupational groups.

The key argument made by Susskind and Susskind (2015) can be broken down into two main strands. First, in contemporary society there is an increasing demand for professional services, at levels that make the continued existence of bespoke, personal, hourly-paid professional services unsustainable. Second, advances in information technology mean that high-quality professional knowledge can be made available through a variety of on-line strategies.

Pressure on current models of professional work arises from the cost of professional services. For example, Susskind and Susskind (2015) offer evidence that commercial companies struggle to meet the costs of expert legal and accountancy advice, healthcare systems are unable to guarantee that high-level medical expertise is available to all patients, and newspapers are unable to afford to support rigorous investigative journalism. The cost of professional services means that most ordinary citizens are unable to access professional assistance at points in their lives when they need it most. As a result, there is a massive unmet need in relation to the kind of specialist knowledge that is currently only (or mainly) accessible through consultation with an appropriately qualified member of a profession.

At the same time as the pressure of unmet need is growing, viable alternatives to traditional one-to-one professional consultation are emerging in the form of techniques for making expert knowledge available through the internet. Susskind and Susskind (2015) provide many examples of how this is already taking place, within all domains of professional life. For example, there are medical information and self-diagnosis websites, sites where legal documents can be downloaded, crowd-sourced problem-solving in areas such as architecture and town planning, and blogs where ordinary citizens function as journalists. One of the most important areas of on-line development, according

to Susskind and Susskind, is what they describe as the 'commons' – shared knowledge contributed and maintained by experts-by-experience.

Susskind and Susskind (2015) identify many sources of resistance to change within the professions: traditional professional roles offer highly satisfying, meaningful, well-paid jobs. Susskind and Susskind suggest that the level of resistance to change is so strong that established professions are likely to find it extremely hard to adapt to social demands and technological change. As a result, the future of professional work will be markedly different. They argue that current professional roles will increasingly be broken down into their constituent tasks. Some tasks will need to be carried out by highly trained experts, other tasks will be delegated to paraprofessional assistants, while others will be able to be fulfilled by on-line packages. In their view, the pace of progress within artificial intelligence and the digitisation of professional knowledge will inevitably result in more and more professional tasks being carried out by machines (robots, remote sensing devices, and websites). Within that scenario, one of the key roles will be for 'empathisers' who will provide the necessary element of human contact not available through human-machine interaction (although they also note that robots are already able to demonstrate emotional intelligence).

What does all this mean for counselling and psychotherapy? It seems likely that the high-point for the counselling and psychotherapy professions, in terms of achieving status and rewards equivalent to the established professions, may have already been reached. The whole direction of travel, according to Susskind and Susskind (2015), is towards breaking down the domination and status of the professions, in order to make expert knowledge more generally accessible. What they call 'the grand bargain', through which professional groups are mandated by society to exert control over certain areas of knowledge and practice in exchange for high standards of self-regulation, would appear to be a thing of the past. It is notable the predictions for the future of counselling and psychotherapy as outlined in surveys by Norcross et al. (2013) and Taylor et al. (2018) assume that the control and delivery of new types of therapy intervention will remain under the control of existing professional organisations. If the analysis of Susskind and Susskind (2015) is valid, this is not what will happen; instead, initiatives will be driven by social and commercial entrepreneurs and community groups that find ways of reinventing, adapting, and re-packaging therapy in specific, cost-effective ways.

On the other hand, the vision of the future of the professions outlined by Susskind and Susskind (2015) could offer significant opportunities to those who possess psychotherapeutic skills and knowledge. The role of 'empathiser' is an obvious candidate as a professional task that could be well suited to therapists. Examples of this already exist. For instance, patients who receive highly technical medical services in areas such as genetic testing and infertility treatment may also be offered the chance to speak to a counsellor about the meaning and emotional impact of their treatment. Individuals who receive professional guidance from financial experts, around debt restructuring, may sometimes also attend counselling to work through the personal implications of the situation within which they find themselves.

The concept of the 'commons' is close to the heart of counselling and psychotherapy. As many commentators have pointed out, basic counselling skills, and the ideas and concepts that reside within theories of psychotherapy, are derived from pre-existing cultural knowledge. In addition, within a culture there are many activities, such as music, outdoor pursuits, and spiritual practice, that are known to have therapeutic benefits. Many therapists already operate within this territory, without explicitly recognising their work as being linked to a common cultural heritage or common social 'good'. Further attention to this aspect of counselling and psychotherapy practice may open up new opportunities and work roles for individuals with therapy training, around making more purposeful and explicit use of everyday activities.

The single most powerful influence on the future of professional roles, according to Susskind and Susskind (2015), will be enhanced access to professional knowledge through technology such as on-line systems, remote sensing, and web-based services. Some of this is already in place: feedback and tracking systems to monitor and review client progress; on-line CBT and other therapy packages;

email counselling; on-line chat rooms and support groups; client recording of behavioural and emotion data through smart phones; virtual reality interventions for anxiety and trauma. In addition, a massive amount of information on mental health, coping, and therapy is available on the internet. Clearly, much more of this is going to happen over the coming decades.

Susskind and Susskind (2015) provide a story that sums up their message. The story is of a training event for managers in a company that makes electric drills. The trainer displays on-screen images of the range of drills made by the company and asks the trainees: 'do you agree that your job is to enable the company to manufacture more efficient and customer-friendly versions of these products?' The trainees all agree. The trainer then displays on screen an image of a hole in a wall and replies: 'no, this is what the customer wants – this is what our company needs to be able to deliver'. In the context of counselling and psychotherapy, the drill can be viewed as the prevailing image of the role of a professional therapist as a well-paid autonomous professional. The hole in the wall represents what the client wants. What Susskind and Susskind (2015) are saying is that when technology starts to come up with different ways of making holes in walls, or ways to attach objects to walls without making holes at all, then traditional electric drills will be quickly replaced by new and different tools.

## Challenges in the relationship between therapy and society

Alongside whatever dynamic of change might be unfolding within the counselling and psychotherapy professions, as well as within the professions at large in contemporary society, there are certain to be broader social changes that will also have an impact on the future shape of therapy provision. Areas where this might happen are considered below.

### Facing up to cultural difference

One of the strongest themes to emerge from horizon-scanning surveys of therapists is that the psychotherapeutic professions have entered a phase of learning how to take account of cultural difference. A central issue concerns the question of harmful therapy. There is extensive evidence, accumulated over several decades, that pure-form mainstream therapies are, on the whole, unhelpful for people from ethnic minority groups (Wendt et al. 2015). A further issue is related to the massive dislocation of peoples that was set in motion by the invasion of Iraq, then exacerbated by events in Syria and Somalia and the effects of global warming. There are vast numbers of refugees suffering from psychological trauma, and it is not at all clear how counselling and psychotherapy can help them (Apostolidou 2016; Kira and Tummala-Narra 2015; Lambert and Alhassoon 2015; Nickerson et al. 2011). If the psychotherapeutic professions are to play a meaningful part in this humanitarian effort, there is an urgent need to develop better ways of making sense of how individuals deal with that level of cultural dislocation. A third critical issue concerns the accelerating expansion of psychotherapy in China, fuelled by increasing prosperity and the creation of an educated middle class, many of whom have lost touch with traditional values and whose network of family connections has been diminished by the one child policy. Some of these people will also have lived through the brutality of Mao's Great Leap Forward (1958–1963). This is fertile territory for psychology and psychotherapy, but at the same time it is beginning to look as though therapy in China is going to be like nothing we have seen before (Hsuan-Ying 2015; Xu and Tracey 2016; Zhang 2014, 2017, 2018). The implications of this, as China moves in the direction of becoming a dominant world economic power, are impossible to predict. Taken together, these issues represent a major challenge for counselling and psychotherapy theory, research, and practice.

## **New technologies, new types of person**

The intense pace of technological and cultural change is a central aspect of contemporary society. Many of the changes that have occurred, or are in the process of unfolding, produce shifts in the way that individuals process information about the world, define themselves, and connect with others. There is an increasing array of pharmacological products that are used to alter mood, intelligence, sexual performance, sleep levels, and many other functions. People who have been brought up in a digital age access and process information in different ways than those who were born in the age of print. Social media mean that communication between persons can be instant, constant, and pervasive. Personalised advertising allows commercial interests access to personal lives on a routine basis. Notions of work and career are in flux. Prosthetic devices can already extend many dimensions of physical capability. Fertility treatments widen the number of possible patterns of parent–child relationship. Surgical procedures and cultural change extend possible patterns of gender identity. The implications of these trends for therapy are hard to predict. Current approaches to therapy are based on ways of understanding human personality and identity that are grounded in a way of life that prevailed in mid-twentieth-century industrial societies. It is not clear whether the human race is moving towards a decisive shift in consciousness and relatedness, or merely into a phase of fragmentation and confusion. In either scenario, it would seem to be necessary for any substantial revisioning of psychological and psychotherapeutic concepts to take place.

## **Environmental collapse**

Global warming is irreversible: climate change is already happening – sea levels are rising. These processes on their own will result in massive social change and disruption. In addition, most cities around the world are responsible for air pollution that has negative effects on health. The seas are gradually becoming silted up with plastic, with consequences that are not yet well understood. There are severe water shortages in many regions. There is an accumulation of waste from nuclear power plants, for which no secure storage has yet been devised. Soil quality is deteriorating. We are killing the planet. At some stage, the degradation of the natural environment will have an enormous impact on therapy. It may be that individualistically focused therapy will be viewed as increasingly irrelevant, and will be replaced by therapeutic practices that are oriented more towards the promotion of social solidarity and support, and personal sacrifice for the common good. It is inevitable that, at some stage, reality about the consequences of modern ways of living will eventually break through current levels of denial, opening up feelings of guilt, anger, and blame. It is possible that this could be accompanied by widespread adoption of forms of spirituality that are consistent with renouncement of materialism and consumerism, and engagement in daily lives that are closer to ecology and nature. The therapeutic preoccupation of the last century, of finding behaviour change strategies to counteract addictions to alcohol, drugs, eating (or not eating), gambling, and sex may be replaced by parallel strategies that help people to consume less, travel less, recycle and mend, and adopt vegan diets. There is likely to be an expansion of therapy approaches to working with internal and cross-border refugees fleeing from conflict zones or areas that are no longer habitable, adoption processes and trauma interventions for unaccompanied children of refugees, and forms of therapeutic support around decisions to limit family size. Therapy concepts and theories will need to be formulated that will allow people to make sense of these experiences.

## **The crisis within democratic processes and institutions**

As the problems facing the world grow, the capacity to act decisively in response to these problems seems to be steadily diminishing. It is possible to identify three key dimensions to the crisis of collective decision-making. First, political systems in many countries, notably the USA and UK, have deteriorated into adversarial polarities, reflected in an unwillingness to compromise and a



disregard for legal process and expert knowledge. Second, at an international level, there is massive investment in military solutions to problems. Most often, for example in Iraq and Libya, military interventions have merely compounded whatever problems already existed. In addition, military expenditures have had the effect of distorting domestic politics. Third, the most serious problems, such as global warming, require joint action at an international level – something that the human race as a whole has signally been unable to accomplish in the past. A major future opportunity for the psychotherapeutic professions lies in developing ways to use therapeutic skills and knowledge, in areas such as promoting dialogue, speaking authentically, and working in groups, as a contribution, alongside other professions and disciplines, to the construction of political and democratic systems that are fit for purpose in relation to the challenges being faced by the human race. One of the implications for therapy practice might be to develop an expanded understanding of the outcomes of therapy, to include the ability to engage in active citizenship and be consciously informed by moral values.

## Conclusions

The future of counselling and psychotherapy is highly relevant to how therapy is practised in contemporary society. Most therapists are trained to use concepts and methods that were developed by previous generations, that reflect the concerns and social conditions of earlier eras. The leaders of therapy training programmes are mid-life clinicians and researchers whose formative life experiences date back to before many of their students were born. At the same time, many clients present with issues that very much reflect the here-and-now. Despite research by Greg Neimeyer and his colleagues (Neimeyer et al. 2012, 2014) showing that the majority of therapists believe that their professional knowledge has a half-life of maybe 5–10 years, few actually act on this information. Because of the immense personal and emotional commitment required to learn an approach to therapy, the majority of therapists end their careers practising a version of therapy that is recognisably similar to the model in which they were originally trained.

There are powerful fears within the world of counselling and psychotherapy that current trends are leading towards a future that will see the ‘death’ of meaningful psychotherapy. For example, Cushman and Gilford (2000) and Polkinghorne (1999) have argued that empirically validated, manualised therapies represent a form of ‘psychotechnology’ rather than an authentically life-enhancing activity; contributors to a collection of papers edited by Loewenthal and Proctor (2018) suggest that the domination of CBT will replace the essential relationship-focused approach of much effective therapy with a sterile therapeutic ‘monoculture’ (Leichsenring et al. 2018). The idea that accompanies such fears is that therapy may lose its capacity to function as a site for personal growth and fulfilment, and instead become a form of social control through which consumers and workers are persuaded to accept whatever it is that the State and/or big business thinks is good for them. The ideas and possibilities discussed in the present chapter, and throughout this book as a whole, can be understood as leading to a different interpretation. Ever since counselling and psychotherapy emerged from religion at the beginning of the twentieth century, it has been faced with the need to reconcile a tension between individual freedom/creativity and social control/conformity. This tension can be viewed as a central element of the essence of what therapy is about, at both the level of individuals seeking help and also the level of therapy as a social institution and resource. The emerging challenges of the next 20 years, whatever they turn out to be, cannot be addressed effectively using tools and ideas from just one side of the freedom–control dichotomy or the other. Instead, they will require effective harnessing of all of the creative energy arising from seeking to accommodate all of the tensions that characterise therapy as a live and meaningful cultural space: not only freedom and control, but also imagination and technology, individual agency and shared community, wisdom and inventiveness, and reason and spirit.



## Topics for reflection and discussion

- 1** In terms of the world that you live in, yourself, what do you see as the emerging issues that will determine the future shape of therapy? Do you regard the issues outlined in the present chapter as valid, or are there other challenges that you believe are more significant?
- 2** Each generation appears to have a distinctive emotional theme that influences many aspects of life and calls for a therapeutic response. The years immediately after the First World War were characterised by loss and nostalgia. The years immediately after the Second World War, and the emergence of nuclear weapons, were a time of anxiety. There was then a phase of disappointed hope, or depression, followed by more recent preoccupation with trauma (failure of safety) and narcissism (a life position built around personal entitlement). Does the existence of such socio-cultural phases make sense to you? If you do believe that such phases have occurred, would you describe them in different terms? What do you think the next phase will look like?
- 3** What are your hopes, in relation to the future of counselling, psychotherapy, and allied disciplines? What are your fears?

## Suggested further reading

*A History of the Future in 100 Objects*, by Adrian Hon (2013), offers an imaginative and ultimately optimistic vision of the complex technical social possibilities with which future therapists may need to engage.



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# Index

## A

- abandonment 107, 138, 247, 347, 449
- Abbass, A.A. and Town, J.M. 114
- Abbass, A.A., Kisely, S., Rasic, D., Town, J.M. and Johansson, R. 480
- Ablow, R. 118
- Abram, D. 252–3
- Abu Ghraib prison 458
- Abu-Raiya, H. 263
- Abu-Rayyan, N.M. 216
- abusive sexuality 392–3
- acceptance and commitment therapy (ACT) 135–6
- accountability 455–8
- acculturation, concept of 350–51
- action research 473, 483  
social action research 404
- Adams, C. 253, 417
- adaptation of services, cultural sensitivity and 357–8
- Addis, M.E. and Martell, C.M. 138
- adjunctive interventions 520
- Adler, Alfred 101, 372
- Adult Attachment Interview (AAI) 108
- adventure therapy 254–5  
case study, action on overcoming eating disorders 254–5
- adversity theory 364
- advocacy, social justice and 400–401
- affect phobia therapy 114
- affluence, significance of 374
- agency  
existential therapy 198  
person-centred therapies 162  
self and 342
- agitated movements 274
- Aiach Dominitz, V. 192
- aims  
agreement on goals 57  
social justice in therapy 396–7  
of therapy, therapist's perspective on 14–15
- Ainsworth, Mary 107–8
- Ainsworth, M.D.S., Blehar, M.C., Waters, E. and Wall, S. 107
- Al-Issa, I. 356
- Albee, G.W. 321, 513
- Aldarondo, E. 396
- Aldridge, S. 333
- Alexander, L.B. and Luborsky, L. 42–3
- Alexander Street Press 15
- Alghazo, R., Upton, T.D. and Cioe, N. 456
- Ali, A. and Sichel, C.E. 400
- Ali, B.S., Rahbar, M.H., Naeem, S., Gul, A., Mubeen, S. and Iqbal, A. 506
- alignment, maintenance of 309–10
- Allen, Frederick 282
- Allen, J.G. and Fonagy, P. 109
- Alliance in Action scale 36–7
- alone-ness 197
- Altmann, U., Zimmermann, A., Kirchmann, H.A., Kramer, D., Fembacher, A., Bruckmayer, E. et al. 480
- Alvarez, K.M., Kenny, M.C., Donohue, B. and Carpin, K.M. 458
- Amendt-Lyon, N. 193
- American Counseling Association (ACA)  
professional structure for therapists 442
- social justice  
orientation 396
- American Personnel and Guidance Association (APGA) 331
- American Psychiatric Association 56, 346
- American Psychological Association (APA) 15, 388, 467
- analogies, use of 131
- analytic psychology 101
- Anastasi, A. 53
- Anchin, J.C. 295
- Anderson, H. 225
- Anderson, H. and Gehart, D. 211, 225
- Anderson, H. and Goolishian, H. 47, 214
- Anderson, P., Jacobs, C. and Rothbaum, B.O. 516
- Anderson, S., Brownlie, J. and Given, L. 21–2, 413
- Anderson, T., Crowley, M.J., Himawan, L., Holmberg, J. and Uhlin, B. 413
- Anderson, T., McClintock, A.S., Himawan, L., Song, X. and Patterson, C.L. 413
- Anderson, Tom 235–6
- Angus, L.E. 73, 168, 218
- Angus, L.E. and Greenberg, L.S. 168
- Angus, L.E. and Rennie, D.L. 37, 73, 487
- animal-assisted therapy 256
- anorexia nervosa 346
- anticipatory anxiety 433–4
- antidepressants, experience of taking 275–6
- Anton, Franz 323
- Antony, M., Ledley, D.R. and Heimberg, R.G. 133

- Antze, P. 508  
 Aponte, H.J. and Kissil, K. 438  
 Apostolidou, Z. 528  
 Appelbaum, A. 53–4  
 Appignanesi, L. 322, 380  
 apps 516  
 Araya, R., Flynn, T., Rojas, G., Fritsch, R. and Simon, G. 521  
 Argyle, M. and Kendon, A. 129  
 Argyle, Michael 129  
 Arkowitz, H., Miller, W.R. and Rollnick, S. 136  
 Armstrong, J. 506  
 Arnette, N.C., Mascaro, N., Santana, M.C., Davis, S. and Kaslow, N.J. 261  
 art in therapy, use of 240–51  
   arts-based therapies, evolution of 240–41  
   arts-informed therapy practice, impact and meaning of 248  
   autobiographical writing 241  
   case study, creative writing after death of child 245  
   cognitive aspect of writing 244  
   creative writing 244–5  
   dance and movement 241, 246–7  
   discussion topics 250  
   dramatherapy, dramatic performance and 241, 246  
   drawing 241, 242–3  
   expressive methods 248  
   expressive therapist's toolkit 247  
   film 241, 247  
   interactive drawing therapy (IDT) 242  
   making art 246–7  
     client experience of, research on 249  
   making sense of therapy, art in 249  
   music 241, 245–6  
   observing art 247  
   painting 241, 242–3  
   Pennebaker paradigm 244  
   photography 241, 243  
   physiological aspect of writing 244  
   poetry writing 241  
   psychoanalysis and 248–9  
   quilting 241  
   reading suggestions 251  
   reflection topics 250  
   representation, modalities of 248  
   research, art in  
     communication of findings of 249–50  
   sand tray play 241  
   sculpture 241, 242–3  
   social aspect of writing 244  
   storytelling 241  
   tapestry 241  
   therapeutic processes associated with art use 247–9  
   therapeutic uses of art, forms of practice 241–7  
   therapeutic writing 243–5  
   writing 243–5  
 Arthern, J. and Madill, A. 40  
 Asdler, Alfred 396  
 Asen, E. and Scholz, M. 232  
 Aslan, L. 257  
 Assagioli, Roberto 264  
 assertiveness training 129  
 assessment  
   computer-based assessment 515  
   focus in CBT on 124  
   identification and quantification of problems 126  
   process of 53–5  
 assimilative integration 294  
 'asylums,' development of 322  
 Asylums Act (UK, 1845) 322  
*ataques de nervois*, culture-bound syndrome of 346  
 Athanasou, J.A. and van Esbroeck, R. 334  
 attachment theory 106–9  
   critical perspectives on 109  
 Audet, C. and Paré, D.A. 396  
 Augusta-Scott, T. 398  
 Austin, Wendy 446  
 authenticity  
   authentic meeting, relationship as place of 29–30  
   existential therapy and 199  
 author-editor relationship 30–31  
 autobiographical writing 241  
 'automatic thoughts' 121–2  
 autonomy  
   autonomous attachment pattern 108  
   existential therapy and 196–7  
   of individuals, ethics and 449, 450  
 avatars 516  
 Aveline, M.O. 53  
 Axline, Virginia 380  
 Ayllon, T. and Azrin, N.H. 118
- B**  
 Bados, A., Balaguer, G. and Saldaña, C. 134  
 Bakan, D. 342  
 Baker, D. and Fortune, S. 4  
 Baker, S.B., Daniels, T.G. and Greeley, A.T. 80  
 Bakhtin, Mikhail 210  
 Balmforth, J. 372  
 Bamelis, L.L., Evers, S.M., Spinhoven, P. and Arntz, A. 138  
 Bamford, J. and Akhurst, J. 88  
 Bandura, Albert 121  
 Bannister, Don 219  
 Barber, J.P., Liese, B.S. and Abrams, M.J. 125  
 Barber, P. 192  
*Barefoot Psychoanalyst* (Southgate, R. and Randall, J.) 517  
 Barker, C. and Pistrang, N. 506  
 Barker, Meg 205, 391  
 Barkham, M. 288, 492  
 Barkham, M. and Shapiro, D.A. 499  
 Barkham, M., Guthrie, E., Hardy, G.E. and Margison, F. 59, 111–12, 497



- Barkham, M., Hardy, G.E. and Mellor-Clark, J. 478
- Barkham, M., Mellor-Clark, J. and Stiles, W.B. 79
- Barkham, M., Stiles, W.B., Hardy, G.E. and Field, S.F. 67, 68
- Barlow, D.H. 484
- Barlow, D.H., Allen, L.B. and Choate, M.L. 134
- Barlow, D.H., Hayes, S.C. and Nelson, R.O. 124
- Barnett, J.E. and Kolmes, K. 515
- Barnett, J.E. and Molzon, C.H. 432
- Barnett, J.E., Wise, E.H., Johnson-Greene, D. and Bucky, S. 458
- Barnett, M. 415
- Barnicot, K., Couldrey, L., Sandhu, S. and Priebe, S. 135
- Barrett-Lennard, G. 42, 152, 153, 156–7, 169, 327, 485
- Bashe, A., Anderson, S.K., Handelsman, M.M. and Klevansky, R. 468
- Bates, C.M. and Brodsky, A. 464
- Bates, Y. 10, 454
- Bateson, Gregory 230, 232
- Batten, S.V. 135
- Bayer, R. 388
- Bayley, John 518
- Bazzano, M. 164
- Beahrs, J.O. and Gutheil, T.G. 458
- Bean, H., Softas-Nall, S. and Mahoney, M. 458
- Beating the Blues* 516
- Beauvoir, Simone de 380
- Bechdel, A. 518
- Beck, Aaron T. 121–2, 123, 134, 137, 138, 143, 295, 326
- Beck Depression Inventory (BDI) 476–7
- Becker-Haimes, E.M., Franklin, M., Bodie, J. and Beidas, R.S. 134
- Beckham, E.E. 86
- On Becoming a Person* (Rogers, C.) 152
- Bedi, R.P. and Duff, C.T. 36
- Bedi, R.P., Davis, M.D. and Williams, M. 7, 36
- Bee, P.E., Lovell, K., Lidbetter, N., Easton, K. and Gask, L. 514
- befriending 369–70
- behaviour change 65–6
- gain of 15
- research on 480
- behaviour experiments 128–9
- behavioural activation therapy 138
- behavioural case studies 489–90
- behavioural experiments 24
- behavioural targets in existential therapy 197
- beliefs, assumptions and cultural sensitivity 340
- beneficence 449–50
- Benelli, E., Bergamaschi, M., Capoferri, C., Morena, S., Calvo, V., Mannarini, S. et al. 182
- Benelli, E., Moretti, E., Cavallero, G.C., Greco, G., Calvo, V., Mannarini, S. et al. 182
- Benítez-Ortega, J.L. and Garrido-Fernández, M. 79
- Benjamin, L.S. 33, 110
- Bennett-Levy, J., Butler, M., Fennell, M., Hackmann, A., Mueller, M. and Westbrook, D. 128
- Bennett-Levy, J., Thwaites, R., Haarhoff, B. and Perry, H. 438
- Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B. and Farmer, S. 438
- Beradt, Charlotte 370
- Berg, A.L., Sandahl, C. and Clinton, D. 52
- Berg, I.K. and Kelly, S. 221
- Berger, Ronen 255
- Bergin, A.E. 447
- Bergner, Raymond 368–9
- Berman, Emanuel 243, 404
- Berman, J.S. and Norton, N.C. 505
- Berne, Eric 106, 171, 172, 176–7, 177–8, 181–2, 183, 326
- Bernhardt, I.S., Nissen-Lie, H., Moltu, C., McLeod, J. and Råbu, M. 416
- Bernstein, B. 344
- Berry, K. and Danquah, A. 108
- Bersoff, D.N. 456–7
- Betan, R.J. and Binder, J.L. 420
- Bettelheim, B. 95
- Beutler, Larry E. 191–2, 285–6
- Beutler, L.E. and Clarkin, J.F. 52
- Beutler, L.E., Engle, D., Daldrup, D., Bergan, R., Meredith, J. and Merry, K. 191
- Beutler, L.E., Malik, M., Alimohamed, A. and Harwood, T.M. 426
- Bevan, A., Oldfield, V.B. and Salkovskis, P.M. 497
- Bhola, P. and Chaturvedi, S.K. 468
- bibliotherapy 517–18
- Bierski, K. 367
- Bike, D.H., Norcross, J.C. and Schatz, D.M. 436
- Bimont, D. and Werbart, A. 25, 71
- Binder, J.L. and Betan, E.J. 111
- Binder, J.L. and Henry, W.P. 413
- Binder, J.L. and Strupp, H.H. 76, 484
- Binder, P.E., Moltu, C., Hummelsund, D., Sagen, S.H. and Holgersen, H. 7
- Binder, P.E., Moltu, C., Sagen, S., Hummelsund, D. and Holgersen, H. 54–5
- Binswanger, L. 200
- Bion, Wilfred 370, 511
- Birtchnell, J. 33

- Blanchard, M. and Farber, B.A. 80, 85, 391, 460
- Blatt, S.J., Sanislow, C.A., Zuroff, D.C. and Pilkonis, P.A. 489
- Blenkiron, P. 131
- Bleuler, Eugen 322
- Bloch, S., Crouch, E. and Reibstein, J. 512
- Bloor, M., McKeganey, N. and Fonkert, D. 509
- Blount, C., Evans, C., Birch, S., Warren, F. and Norton, K. 477
- Boal, Augusto 226–7
- Bobes, T. and Rothman, B. 510
- bodily integrity, ethics and 452
- bodily processes, paying attention to 273–4
- bodily responses of therapists 274
- Bohart, A.C. 153, 157, 162, 248, 249
- Bohart, A.C. and Tallman, K. 71, 517, 519
- Bohart, A.C. and Wade, A. 162
- Bohart, A.C., Humphrey, A., Magallanes, M., Guxman, R., Smiljanich, K. and Aguillo, S. 157
- Boker, J.R., Shapiro, J. and Morrison, E.H. 430
- Bond, T. 458
- Bondi, L., Fewell, J. and Kirkwood, C. 506
- Borca, M. and Rober, P. 50
- Bordin, E.S. 31, 163, 485
- Borkosky, B. and Smith, D.M. 461
- Borrill, J. and Foreman, E. 74, 125
- Boss, M. 200
- Boulton, M.J. 509
- boundaries  
     boundary violations, sexual misconduct and 465  
     management of, ethics and 461–7  
     significance when working with families 231  
     therapy as boundaried relationship 41–2
- Bourdieu, Pierre 365
- Bourguignon, E. 271, 323
- Bovopoulos, N., Jorm, A.F., Bond, K.S., LaMontagne, A.D., Reavley, N.J., Kelly, C.M. et al. 507
- Bowen, Murray 232
- Bowens, M. and Cooper, M. 37
- Bower, P. and Gilbody, S. 521
- Bowie, C., McLeod, J. and McLeod, J. 9, 10, 76, 460, 484
- Bowker, P. and Richards, B. 349
- Bowlby, John 96, 106–7
- Boyle, M. 363
- Bozarth, J. 158
- Braaten, E.B., Otto, S. and Handelsman, M.M. 459
- Brabender, V., Smolar, A. and Fallon, A. 511
- bracketing rule in existential therapy 201
- Bragesjo, M., Clinton, D. and Sandell, R. 51
- brain  
     brain fog, culture-bound syndrome of 346  
     ‘gut brain’ functioning 274  
     hemispheric functioning 277–8
- Branson, A., Shafran, R. and Myles, P. 411
- Bratter, T.E. 460
- breathing 273
- Brenes, G.A., Ingram, C.W. and Danhauer, S.C. 513, 515
- Brennan, M.A., Emmerling, M.E. and Whelton, W.J. 169
- Bretherton, I. and Waters, E. 107
- Breuer, Josef 28–9
- Brief Family Therapy Center in Milwaukee 221–2
- brief psychodynamic therapy 110–14
- Bright, J.I., Baker, K.D. and Neimeyer, R.A. 505, 506
- Brightman, B.K. 415, 418
- Brinegar, M.G., Salvi, L.M., Stiles, W.B. and Greenberg, L.S. 68
- Brink, D.C. and Farber, B.A. 157
- British Association for Counselling and Psychotherapy (BACP) 284, 333, 454–5, 467  
     competence in therapists, professional structure for support of 442  
     historical context of contemporary practice 333
- British Association for Counselling (BAC) 331, 333
- British Independent group in psychodynamic tradition 104–5
- British Psycho-Analytical Society 101, 104–5
- Britton, R. 110
- broaching cultural issues 353–4
- Bromley, E. 372
- Brooks, C.F. 386
- Brooks, G.R. 491
- Broverman, L.K., Broverman, D., Clarkson, F.E., Rosencrantz, P.S. and Vogel, S.R. 380
- Brown, B. 517
- Brown, G.W. and Harris, T. 363
- Brown, J. 234
- Brown, Laura 155
- Brown, L.S. 462
- Brown, R. and Strozier, M. 458
- Brownell, P. 187
- Bruneau, L., Bubenzer, D.L. and McGlothlin, J.M. 518
- Bruner, Jerome S. 248
- Brunner, J. 396
- Buber, Martin 29–30, 201
- Buchalter, S.I. 243

- Buckley, P., Karasu, T.B. and Charles, E. 436
- Buckroyd, J. 483
- Bugas, J. and Silberschatz, G. 57
- Bugental, J. 151, 200
- Buhler, Charlotte 151
- building a therapeutic relationship 36–9
- building psychodynamic tradition, key contributions 100–110
- bulimia nervosa 346
- Burgess, M. 131
- Burke, B.L., Arkowitz, A. and Menchola, M. 137
- Burke, E., Danquah, A. and Berry, K. 108, 491
- Burlingame, G.M. and Barlow, S.H. 505
- burnout 440–41  
     dimensions of burnout syndrome 441  
     prevention of trauma and 441
- Burns, D.D. 517
- Burns, G. 23
- Burr, V. 210
- Burton, A. 415
- Burton, M.V. and Topham, D. 415, 417
- Bury, C., Raval, H. and Lyon, L. 4, 6, 7, 64, 114
- Busch, A.M., Kanter, J.W., Callaghan, G.M., Baruch, D.E., Weeks, C.E. and Berlin, K.S. 148
- Butler, G. 25
- Butler, M. 131
- Butt, T. 210
- C**
- Cahalan, William 256–7
- Cain, D.J. 151
- Cain, D.J., Keenan, K. and Rubin, S. 151
- Callahan, J.L., Almstrom, C.M., Swift, J.K., Borja, S.E. and Heath, C.J. 434
- Calmer Life programme 262
- Campbell, L.F. and Smith, T.P. 518
- capabilities perspective, ethics and 452–3
- Caplan, G. and Grunebaum, H. 512–13
- care  
     concept of 453  
     of insane people, debates about 322–3  
     in relational-cultural therapy 384
- career development 442
- Carey, M., Walther, S. and Russell, S. 215
- Carey, T.A. 498
- Carey, T.A. and Mullan, R.J. 128
- Carkhuff, R.R. 428
- Carrell, S.E. 23, 286, 308
- Carroll, M. 432
- Carroll, M. and Gilbert, M. 432
- Carroll, M. and Shaw, E. 454
- case formulation  
     agreement on origins and maintenance of problems 127  
     construction of 419  
     contracting and 57–8  
     focus in CBT on 125
- case studies  
     bowel problems, psychodynamic conversations about 112–13  
     creative writing after death of child 245  
     ‘duty to protect and warn,’ ethical dilemmas in 456–7  
     Eri Viass, exceptional therapist 423  
     experiential focusing 160  
     family sculpting 236  
     ‘Gloria’ tapes of sequential therapy sessions 188  
     ‘Irvina’ contemporary Gestalt practice in case of 190–91  
     men’s therapy 387  
     neglect and abuse in foster care 369
- open dialogue in action 226
- overcoming loss and life-threatening uncertainty 205
- panic attacks, dealing with 237
- personal impact of therapy training 429
- psychodynamic therapy in practice 100
- quasi-judicial case studies 490
- reflections of therapy client 8
- religiously enhanced CBT 262
- research to inform practice 489–91
- resurgence of interest in research on 490–91
- ritual in therapy, use of 237–8
- ‘Rose’ case report in Gestalt therapy 188
- shared understanding, development of 304
- single-session existential therapy 204
- symptom-oriented *vs.* person-oriented approaches 291–2
- systematic case studies 489, 490
- talking about religion in therapy groups 263
- Tarasoff case 456–7
- therapy using experiential focusing 160
- transactional analysis (TA) in action 181
- transpersonal themes, exploration in brief transactional analysis psychotherapy 265
- traumatic bereavement, culturally sensitive counselling for 354
- Casement, P. 105
- Cashdan, S. 104
- Castonguay, L.G. and Hill, C.E. 69

- Castonguay, L.G., Nelson, D.L., Boutsellis, M.A., Chiswick, N.R., Damer, D.D., Hemmelstein, N.A. et al 492
- catastrophisation 123
- Cathexis Institute 180
- causal sequences in CBT, attention to 119–20
- Cavanagh, K. and Shapiro, D.A. 516
- Cavanagh, K., Shapiro, D.A., Van Den Berg, S., Swain, S., Barkham, M. and Proudfoot, J. 516
- Cavanagh, K., Zack, J.S., Shapiro, D.A. and Wright, J.H. 516
- challenge
- ethics and use of 459–61
  - therapist's perspective 21
- Chang, D.Ferk, A. 7
- change
- awareness and change, strategies for facilitation of 189–91
  - change events, use of ritual to create memorable events 238
  - change events and processes, dichotomy between 63–4
  - cognitive change, gain of 15
  - difficulties in process of 7
  - facilitation of 310–12, 315
  - resistance to change 527
  - social change, leaving clients with tools for 397
  - social change, reshaping therapy in response to 329–30
  - solution-focused therapy and focus on 222–3
  - structural change, research on 482
  - therapeutic process of 63–4
  - Western society, nature of change in 320
- Charcot, Jean-Martin 323
- chat rooms 516
- Chaturvedi, S. 436
- Chen, C.K., Ingenito, C.P., Kehn, M.M., Nehrig, N. and Abraham, K.S. 113
- Cherniss, C. and Krantz, D.L. 441
- Chesler, Phyllis 464, 465
- Cheston, Sharon 91
- Chew-Graham, C., Brooks, J., Wearden, A., Dowrick, C. and Peters, S. 125
- Chiari, G. and Nuzzo, M.L. 219
- Chiesa, M., Drahorad, C. and Longo, S. 9
- Childline 502
- children
- child protection 457–8
  - emotional problems, childhood origins of 95–6
  - techniques for dealing with 100
- Childs-Gowell, E. 180
- Chinese temple, counselling in 347
- Chodorow, N. 382
- choice, reality therapy and concept of 289
- Chow, D. 60, 216
- Chow, D.L., Miller, S.D., Seidel, J.A., Kane, R.T., Thornton, J.A. and Andrews, W.P. 439
- Chow, P.I., Wagner, J., Lüdtke, O., Trautwein, U. and Roberts, B.W. 481–2
- Christensen, A. and Jacobson, N.S. 505
- Christopher, J.C. 412
- Chung, R.C.Y. and Bemak, F.P. 396, 399
- clarification 20–21
- Clark, D.A. 134
- Clarke, P.B., Giordano, A.L., Cashwell, C.S. and Lewis, T.F. 267
- Clarkson, P. 32
- Clarkson's five relationship model 32
- Claxton, G. 276
- Clemence, A.J., Fowler, J.C., Gottdiener, W.H., Krikorian, S., Charles, M., Damsky, L. et al. 72
- How Clients Make Therapy Work: The Process of Active Self-Healing* (Bohart, A. and Tallman, K.) 162
- client's perspective 3–12
- availability of therapy 4
  - case study, reflections of therapy client 8
  - change, difficulties in process of 7
  - client assessment of therapists 55
  - client-counsellor CBT collaboration, notion of 125
  - client homework, behaviour change and 66
  - client satisfaction studies 474–5
  - clients of therapists, delivery formats and 509–13
  - cognitive behavioural therapy (CBT) 4
  - connection making 6–7
  - consuming psychotherapy 5
  - deciding to see a therapist 3
  - difficult strands of therapy 7
  - disappointment 10
  - discussion topics 11–12
  - ending therapy 8–9
    - different types of ending 9
  - evaluation of therapy 9–11
  - existential therapy, client-therapist relationship in 200–201
  - exploratory model, working with 352
  - gender and sexuality, client experiences 377
  - getting started 4–5
  - initial contracting meeting 5

- internalisation of
  - therapist 34–5
- involvement, getting involved 5–6
- ‘journey’ of therapy 10–11
- obsessive compulsive disorder (OCD), living with 9
- online information 4
- personal qualities of
  - therapist and client experience 418
- reading suggestions 12
- reasons for ending
  - therapeutic process 85
- reflection topics 11–12
- relevance of research for clients 492
- returning to therapy 11
- therapeutic relationship, management of 7
- therapy theories,
  - formulation of 3–4
- transition phase 6
- willingness (and capacity) to connect 6–7
- working together 7
- Clift, S. and Camic, P.M. 241
- ‘coaching,’ concept of 30, 334
- Coelho Junior, N.E. 110
- Cognition and Behavior Modification* (Mahoney, M.) 124
- cognitive analytic therapy (CAT) 290
- Cognitive-Behavior Modification: An Integrative Approach* (Meichenbaum, D.) 124
- cognitive-behavioural therapy (CBT) 116–41
  - abandonment 138
  - acceptance and commitment therapy (ACT) 135–6
  - analogies, use of 131
  - assertiveness training 129
  - assessment
    - focus on 124
    - identification and quantification of problems 126
  - ‘automatic thoughts’ 121–2
  - behavioural concepts and methods, application in therapy 118–20
  - behaviour experiments 128–9
  - behavioural activation therapy 138
  - case formulation
    - agreement on origins and maintenance of problems 127
    - focus on 125
  - catastrophisation 123
  - causal sequences, attention to 119–20
  - client-counsellor
    - collaboration, notion of 125
  - client’s perspective 4
  - cognition problems,
    - identification and quantification of 126
  - cognitive approaches,
    - emergence of 121–4
  - cognitive distortion 122
  - cognitive schema 138
  - collaborative
    - empiricism 119
  - compassion-focused therapy 138
  - contextualism 119
  - critical issues in CBT theory
    - and practice 133–4
  - cultural origins of CBT 118
  - dialectical behaviour therapy (DBT) 135
  - dichotomous thinking 122
  - discussion topics 140
  - effectiveness of CBT,
    - research on 133
  - exposure techniques 129
  - fear of flying, help in overcoming 125–6
  - functional analysis 119
  - functional analytic psychotherapy 137
  - homework 130
  - imagery rescripting 129–30
  - intervention, focus on 125
  - intervention strategies,
    - application of techniques 128–31
  - ‘irrational beliefs’ 122–3
  - limitations of purely
    - behavioural perspective 121
  - memory, cognitive
    - distortion and role of 123
  - metacognition 123
  - metacognitive therapy 138–9
  - metaphor, use of 131
  - mindfulness 130–31
  - mindfulness-based
    - cognitive therapy (MBCT) 137
  - monitoring, focus on 125
  - monitoring, ongoing
    - assessment of target behaviours 131
  - motivational
    - interviewing 136–7
  - obsessional rituals, dealing with 132
  - origins and development of CBT 117–21
  - over-generalisation 122
  - personalisation 122
  - practice of CBT 124–33
  - problem behaviours,
    - identification and quantification of 126
  - rapport, establishment of 125
  - rational emotive behaviour therapy, Ellis and 122
  - reading suggestions 141
  - reflection topics 140
  - relapse prevention, focus on 125
  - relapse prevention,
    - termination and planned follow-up 132–3
  - schema therapy 138
  - self-critical cognitions 121–2
  - self-help learning
    - materials 131
  - social skills training 129



- cognitive-behavioural therapy (CBT) (*Continued*)
  - Socratic dialogue 128
  - stories, use of 131
  - systematic desensitisation and exposure 120–21
  - therapeutic focus, quantification in maintenance of 132
  - therapeutic relationship 125
  - therapeutic relationship, focus on 124
  - third wave CBT
    - flourishing of 134–40
    - reflections on 139–40
  - transdiagnostic approach 134
  - working alliance, creation of 125
- Cognitive Therapy and the Emotional Disorders* (Beck, A.) 121
- Cohen, L.H., Sargent, M.H. and Sechrest, L.B. 492
- Cohen, L.J. 77
- Cohn, H.W. 200
- Cohn, H.W. and Du Plock, S. 200
- Coleman, James 365, 389
- collaboration
  - capacity for collaborative relationships, research on 473
  - collaborative empiricism 119
  - feedback in promotion of family therapy, use of 238
  - narrative collaborative therapy 225
  - pluralistic therapy, collaborative case formation in 308–9
  - with practitioners from other occupational groups 401
- collective integration 296
- collective self 342
- Coltart, N.E.C. 53
- combination
  - combining delivery formats 520–22
  - integrative therapies and trend towards 297–8
  - with other therapeutic approaches, Gestalt therapy and 193
- Combs, G. and Freedman, J. 211, 212
- Coming Back to Life* (Macy, J. and Brown, M.Y.) 253
- common factors
  - contextual model and 287–8
  - integrative therapies and 283, 287–8
- common language for therapy 295–6
- ‘commons’ concept of 527
- communion, self and concept of 342
- communities as clients 512–13
- community-based voluntary bereavement counselling 373
- community of self 69
- compassion-focused CBT 138
- competence
  - ethical and moral framework 451
  - multicultural therapies, competencies for 359–60
  - working within limits of 461
- competence in therapists, professional structure for support of 425–44
- American Counseling Association (ACA) 442
- anticipatory anxiety, excitement and 433–4
- anxiety and continued dependency stage 434
- arts in training, use of 430
- British Association for Counselling and Psychotherapy (BACP) 442
- burnout 440–41
  - dimensions of burnout syndrome 441
  - prevention of trauma and 441
- calm and congeniality stage 434
- career development 442
- case study, personal impact of therapy training 429
- continuing professional development (CPD) 430–31
- counsellor training
  - programs in US 426–7
- ‘cyclical’ model of supervision 433
- deliberate practice 439–40
  - self-practice and 440
- dependency stage 434
- development stages 433–4
- discussion topics 443–4
- effectiveness, supervision and 434–5
- exuberance and taking charge stage 434
- identification stage 434
- identity and independence stage 434
- institutions 442
- interpersonal skills, counselling and 428–9
- journaling 437
- lifelong learning, preparation for 430
- meditation 437
- personal development 429
- personal therapy 435–6
  - experiences of, diversity of 437
  - impact on practice 436
- post-qualification training 430–31
- primary training 427–30
- professional issues, training and 430
- Psychotherapy and Counselling Association of Australia (PACFA) 442
- reading suggestions 444
- reflection topics 443–4
- research 442–3
- research-informed practice 430

- competence in therapists,  
     professional structure  
     for support of  
     (*Continued*)  
     secondary  
         traumatisation 441  
     self-practice 438, 440  
     skills training 427–8  
     social ecology of  
         professional  
         therapy 443  
     suicide, responding to 431  
     supervised practice 430  
     supervision 431–5  
     supervision formats 432  
     supervision modes 432  
     supervision process  
         model 432–3  
     supervision themes 433–4  
     theoretical framework,  
         acquisition of 428  
     therapist self-awareness,  
         enhancement of 435–40  
     therapist self-awareness,  
         theoretical frameworks  
         for 438  
     therapy agencies and  
         clinics 442  
     therapy supervision,  
         functions of 432  
     training 426–31  
     vicarious  
         traumatisation 441  
     well-being, supervision  
         and 434–5  
     well-being of  
         therapists 440–42  
     complementary  
         transactions 176  
     complex problems, making  
         sense of 19  
     computer-based  
         assessment 515  
     conceptual ability 411, 418–20  
     confidentiality 455–8  
     confrontation 39  
     congruence  
         presence and 157–8  
         value for therapy of 158  
     connectedness in relational-  
         cultural therapy 383  
     connection making from  
         client's perspective 6–7  
     Connell, J., Grant, S. and  
         Mullin, T. 86  
     consciousness-raising,  
         facilitation of 397  
     *Constructive Psychotherapy*  
         (Mahoney, M.) 219  
     constructivism 209–10  
     constructivist therapy 219–21  
         loss or bereavement,  
             constructivist  
             counselling for 221  
         mirror time, use in 220  
         for PTSD, use of metaphor  
         in 220–21  
     *Consumer Reports* study 481,  
         482  
     contact, concept of 189  
     contact work 166  
     contagious ego state 175  
     Conte, H.R. and Ratto, R. 54  
     context, integrative therapies  
         and confusions of 284–5  
     contextualism 119  
     continuing professional  
         development  
         (CPD) 430–31  
     continuum of client-therapist  
         relationships 463  
     contracting 57–8  
     conversation 209, 227  
         core process of 49–50  
         in families 232  
     Cooper, K., Gillmore, C. and  
         Hogg, L. 483, 492  
     Cooper, M. and Knox, R. 164  
     Cooper, M. and McLeod, J. 74,  
         488  
     Cooper, M. and Norcross,  
         J.C. 37, 52  
     Cooper, M., Mearns, D., Stiles,  
         W.B., Warner, M. and  
         Elliott, R. 163  
     Cooper, Mick 31, 200, 203, 306  
     Cooter, R. 322  
     CORE (Clinical Outcomes  
         Routine Evaluation)  
         scale 478, 479  
     core conflictual relationship  
         theme (CCRT) 486  
     Coren, S. and Farber, B. 432  
     Corey, G., Corey, M.S.,  
         Callanan, P. and  
         Russell, J.M. 511  
     Corey, G. 511  
     Cormack, J. 372  
     Cornell, A.W. 160  
     Correia, E.A., Cooper, M. and  
         Berdondini, L. 200, 206  
     Correia, E.A., Cooper, M.,  
         Berdondini, L. and  
         Correia, K. 200  
     Cosgrove, L. and Wheeler, E. 56  
     cost-effectiveness  
         research 480  
     Costa, L. and Altekruze,  
         M. 456  
     Costin, C. and Johnson,  
         C.L. 316  
     *Counseling and*  
         *Psychotherapy* (Rogers,  
         C.) 152  
     Counseling Psychology  
         Division of  
         the American  
         Psychological  
         Association 396  
     counselling  
         counselling skills 20–21  
         therapist use of 378  
         counsellor training  
         programs in US 426–7  
         emergence of 330–33  
         humanistic counselling 169  
         psychological therapies and,  
             demand for 334–5  
         and psychotherapy, critical  
         perspectives on role  
         of 324  
     countertransference  
         disciplined use of 99  
         psychodynamic  
         tradition 104–5  
         therapeutic relationship 29  
     couples as clients 510–11  
     courage  
         ethical and moral  
         framework 451  
         therapeutic process 70–71  
     Courcha, P. 166  
     Cowie, H. and Wallace, P. 509

- Cragun, C.M. and Friedlander, M.L. 262
- Craig, M., Vos, J., Cooper, M. and Correia, E.A. 207
- Crandall, R. and Allen, R. 503
- Crawford, M.J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P. et al. 76, 484
- Crawley, J. and Grant, J. 510
- creative writing 244–5
- critical consciousness, notion of 396
- critical issues in CBT theory and practice 133–4
- Crits-Christoph, P. and Gallop, R. 489
- Crits-Christoph, P., Cooper, A. and Luborsky, L. 486
- Crits-Christoph, P., Gibbons, M.B.C., Crits-Christoph, K., Narducci, J., Schamberger, M. and Gallop, R. 431
- Crocket, K., Drewery, W., McKenzie, W., Smith, L. and Winslade, J. 217
- cross-cultural therapy, qualitative research on experience of 351
- crossed transactions 176
- crossup in games 177
- Csiernik, R. 500
- Cuijpers, P. 483
- Cuijpers, P., Donker, T., van Straten, A., Li, J. and Andersson, G. 519
- Cuijpers, P., Donker, T., Weissman, M.M., Ravitz, P. and Cristea, I.A. 144
- Cuijpers, P., Driessen, E., Hollon, S.D., van Oppen, P., Barth, J. and Andersson, G. 158
- Cullen, C. 119
- cultural adaptation 357–8
- cultural and philosophical influences in Gestalt therapy 185–7
- cultural beliefs and practices, diversity of 345–9
- cultural construction of psychotherapy 336
- cultural curiosity and humility 352–3
- cultural difference awareness of 339 in ethical values and perspectives 468 facing up to 528
- cultural experience, dimensions of 345
- cultural feminism 379
- cultural identity 340 externally observable dimensions of 344–5 intersectionality and 350–51
- cultural matching, complexities of 355–6
- cultural minority, challenge of being therapist in 353
- cultural specificity in person-centred therapies 161
- cultural themes, development of practice and 336
- cultural wealth, taking account of 360
- culturally sensitive therapy 338–61 acculturation, concept of 350–51 adaptation of services to suit different cultures 357–8 agency and self 342 anorexia nervosa 346 *ataques de nervois*, culture-bound syndrome of 346 beliefs and assumptions 340 brain fog, culture-bound syndrome of 346 broaching cultural issues 353–4 bulimia nervosa 346 case study, traumatic bereavement, culturally sensitive counselling for 354 Chinese temple, counselling in 347 client's exploratory model, working with 352
- collective self 342
- communion, self and concept of 342
- competencies for multicultural therapies 359–60
- cross-cultural therapy, qualitative research on experience of 351
- cultural adaptation 357–8
- cultural beliefs and practices, diversity of 345–9
- cultural curiosity and humility 352–3
- cultural difference, awareness of 339
- cultural experience, dimensions of 345
- cultural identity 340 externally observable dimensions of 344–5 intersectionality and 350–51
- cultural matching, complexities of 355–6
- cultural minority, challenge of being therapist in 353
- cultural wealth, taking account of 360
- culturally diverse healing practices 346–9 implications of 349
- culturally sensitive therapy, general strategies for 351–2
- culturally sensitive therapy in action 351–60
- 'culture,' meaning of 339–45
- culture-bound syndromes 345–6
- dimensions of culture, externally observable 340–41
- discussion topics 361
- djinatti*, culture-bound syndrome of 346
- dualistic view of reality 341
- emotion, expression of 344
- empathy 352–3

- ethnic client-therapist  
   matching 354–7  
 fate, operation of 342  
 functioning of cultures 340  
 future-orientation 343  
 gender relationships 344  
 guidelines for multicultural  
   therapies 359–60  
 healing, theory of 344  
 healing lament in  
   Finland 347–8  
 healing practices 346–9  
   implications in cultural  
   diversity of 349  
*hikikomori*, culture-bound  
   syndrome of 346  
 humility 352–3  
 individualistic self 342  
 initiation of conversations  
   about cultural  
   issues 353–4  
 intersectionality 350–51  
*karma*, Hindu notion of 342  
 kinship patterns 344  
 language, significance  
   of 349–50  
 Maori philosophy of life 348  
 matching client-therapist  
   culturally 354–7  
 microaggression, invisible  
   dynamics of cultural  
   difference 358–9  
 morality, construction  
   of 342  
 multiculturalism, responses  
   to trend towards 339  
*Naikan* therapy in  
   Japan 348  
 Native American sweat lodge  
   ceremonies 348–9  
 non-verbal behaviour 344  
 past-orientation 343  
 place, significance of 343  
 present moment 343  
 problems of living, diversity  
   of beliefs and practices  
   about dealing with  
   345–9  
 progress, notion of 343  
 ‘race-avoidant’  
   interventions 353  
 reality, concept of 341  
 referential self 342  
 reflection topics 361  
 ritual healing, Ndembu  
   doctor and 347  
 self-sense of 341–2  
*shinkeishitsu*, culture-  
   bound syndrome of 346  
 theoretical basis for, need  
   for coherence in 360  
 time, concept of 342–3  
 verbal behaviour 344  
   Western ideas, relevance in  
   Islamic societies 356–7  
 Cummings, A.L., Hallberg, E.T.  
   and Slemon, A.G. 487  
 Cummings, N.A. 500  
 Cummings, N.A. and Sayama,  
   M. 500  
 Cunha, C., Gonçalves, M.M.,  
   Hill, C.E., Mendes, I.,  
   Ribeiro, A.P., Sousa, I.  
   et al. 218  
 Curtin, L. and Hargrove,  
   D.S. 463  
 Cushman, P. 143, 325, 342, 374,  
   400, 448  
 Cushman, P. and Gilford,  
   P. 346, 530  
 ‘cyclical’ model of  
   supervision 433
- D**
- Dale, P., Allen, J. and Measor,  
   L. 85  
 Dalenberg, C.J. 413  
 Dallos, R. and Draper, R. 231  
 dance and movement 241,  
   246–7  
 Danchev, D. and Ross, A. 491  
 Daniels, J. and Wearden,  
   A.J. 125  
 Dare, C. and Eisler, I. 232  
 Davanloo, Habib 110, 114  
 Davenport, S., Hobson, R. and  
   Margison, F. 112  
 Davidson, L., Harding, C. and  
   Spaniol, L. 508  
 Davies, D. and Barker, M. 389  
 Davies, J. 56  
 Davis, J. 50  
 Davis, K. 460  
 Davison, K.P., Pennebaker, J.W.  
   and Dickerson, S.S. 508  
 Day, E. 189  
 Day-Vines, N.L., Bryan, J. and  
   Griffin, D. 353  
 De Jong, K. and de Goede,  
   M. 504  
 De Jong, K., van Sluis, P.,  
   Nugter, M.A., Heiser,  
   W.J. and Spinhoven,  
   P. 79  
 De Shazer, Steve 221–2, 223,  
   224–5  
 death  
   creative writing after death  
   of child 245  
   existential therapy 197–8  
   loss or bereavement,  
     constructivist  
     counselling for 221  
   traumatic bereavement,  
     culturally sensitive  
     counselling for 354  
 deep ecology 252–3  
 deep issues, thinking  
   about 195–6  
 defences  
   identification and analysis  
   of 99  
   mechanisms of 98  
 deflection in Gestalt  
   therapy 189  
 Delfstra, G. and van Rooij,  
   W. 113  
 Delgadillo, J., Gellatly, J. and  
   Stephenson-Bellwood,  
   S. 522  
 deliberate practice 439–40  
   self-practice and 440  
 delivery formats for better  
   access and effect  
   495–523  
 adjunctive  
   interventions 520  
 apps 516  
 avatars 516  
*Beating the Blues* 516  
 bibliotherapy 517–18  
 chat rooms 516  
 Childline 502

- delivery formats for better access and effect  
(*Continued*)
- clients of therapists? 509–13
- combining formats 520–22
- communities as clients 512–13
- computer-based assessment 515
- couples as clients 510–11
- discussion topics 522–3
- email counselling and psychotherapy 515
- embedded counselling 507–8
- employee assistance programmes (EAPs) 503
- ethical concerns in brief therapy 500
- families as clients 511
- FearFighter* 516
- frequency of sessions 497–8
- Improving Access to Psychological Therapies (IAPT) initiative 504, 521
- individuals as clients 509–10
- intermittent therapy 500–501
- Internet technologies 514–17
- length of sessions 497–8
- long-term therapy 498
- low-intensity support workers 507
- national statutory agencies 503
- New Public Management 503
- non-professional counsellors 505–6
- online assessment 515
- online therapy sites 516
- organisational contexts 502–4
- organisational cultures 503–4
- paraprofessional counselling 506–7
- peers 509
- place considerations 502–4
- prevention, concept of 512–13
- professional therapists 504
- programmes, communities and 520
- reading suggestions 523
- reflection topics 522–3
- RELATE 502
- resource factors, time-limited therapy and 500
- self-help groups 508–9
- self-help materials 517–20
- self-help mental health books 517–18
- self-help reading, reviews of effectiveness of 519
- self-help sources, diversity of 519–20
- single-session therapy 501–2
- stepped care 520–22
- technologies 513–17
- telephone counselling 513–14
- text messaging 516
- therapeutic communities 509
- time considerations 497–502
- time-limited therapy 498–500
- video link communication 515
- virtual reality 516
- voluntary counselling agencies 502
- who can be a therapist? 504–9
- DeLucia-Waack, J.L., Gerrity, D.A., Kalodner, C.R. and Riva, M. 511
- democratic processes, crisis within 529–30
- 'demonology' 322
- Den Boer, P.C., Wiersma, D., Russo, S. and van den Bosch, R.J. 505, 519
- Denborough, D. 211, 216–17, 368, 512
- Denborough, D., Freedman, J. and White, C. 217
- Denborough, D., Koolmatrie, C., Mununggirritj, D., Marika, D., Dhurrkay, W. and Yunupingu, M. 217
- denial 97, 98, 103, 108, 257, 381, 386, 529
- depersonalisation 206
- depression  
feminist approach to 384  
social origins of 363–4
- Descartes, René 341
- description rule in existential therapy 201
- Devlin, A.S. and Nasar, J.L. 40
- Devlin, A.S., Nasar, J.L. and Cubukcu, E. 40
- DeWaele, J.P. and Harré, R. 489
- diagnosis 55–7
- Diagnostic and Statistical Manual (DSM) 56, 346
- dialectical behaviour therapy (DBT) 135
- Dialogical Feedback Tool (DFT) 238
- dialogical therapy 225–6  
case study, open dialogue in action 226  
open dialogue approach, success factors for 225–6
- dialogue  
narrative approaches to therapy 227  
in pluralistic therapy  
implication of 301  
value of 312  
therapeutic process 50  
use of feedback in promotion of 238
- Diamond, G.M. 109, 232
- DiCaccavo, A. 415
- dichotomous thinking 122
- Dickerson, V. 232
- Dickson, W. 332
- difficult process, Warner's perspective on 164–5
- Dimidjian, S. and Hollon, S.D. 484
- disabilities  
biomedical model of 403  
counselling people with 402–3



- functional model of 403
- disappointment 10
- disconnection, strategies of 164
- discovery, Gestalt process of 189
- discussion topics
  - art in therapy, use of 250
  - beginning therapy 61
  - client's perspective 11–12
  - cognitive-behavioural therapy (CBT) 140
  - competence in therapists, professional structure for support of 443–4
  - culturally sensitive therapy 361
  - delivery formats for better access and effect 522–3
  - embodied conversations 279–80
  - ending therapy 89
  - ethical and moral framework 469
  - existential therapy 207
  - families, working with 239
  - future challenges 531
  - gender and sexuality 393–4
  - Gestalt therapy 194
  - hard work of therapy 82
  - historical context of contemporary practice 337
  - integrative therapies 298
  - interpersonal therapies 149
  - narrative approaches to therapy 228
  - outdoor environment, therapy in nature and use of 258
  - person-centred therapies 170
  - pluralistic therapy 315–16
  - psychodynamic tradition 115
  - qualities of effective therapists 424
  - religion and spirituality 269
  - research to inform practice 493–4
  - social concerns, therapy and 375
  - social justice orientation 405
  - therapeutic relationship 45
  - therapist's perspective 26
  - transactional analysis 183
- disengagement 39
- dismissive attachment pattern 108
- disorder-based integrative approaches 293
- disorganised attachment pattern 108
- displacement 98
- Dissanayake, E. 240
- distancing 367
- djinatti*, culture-bound syndrome of 346
- Dobson, K.S. and Dozois, D.J.A. 124
- Dodds, P., Morton, I. and Prouty, G. 166
- Dolan, Yvonne 221
- Dollarhide, C.T., Shavers, M.C., Baker, C.A., Dagg, D.R. and Taylor, D.T. 7
- Dolliver, R.H. 187
- domestic violence, support groups among survivors of 365
- Donovan, J.M., Osborn, K.A. and Rice, S. 114
- Doran, J.M., Safran, J.D., Waizmann, K.B. and Muran, J.C. 43
- Douge, J. 216
- Douglas, A., Ablett-Tate, N. and Chadd, N. 113
- Dowding, K. 397
- Dowling, M. and Rickwood, D. 516
- Dragioti, E., Dimoliatis, I. and Evangelou, E. 477
- drama triangle in games 177
- dramatherapy, dramatic performance and 241, 246
- drawing, art in therapy and 241, 242–3
- dreams
  - dream imagery, Gestalt use of 189
  - working with 99
- Dreier, O. 6
- Drewery, W. 398
- Drewitt, L., Pybis, J., Murphy, D. and Barkham, M. 169
- Dreyfus, Hubert 410
- Dreyfus model of effective therapy 410
- Driessen, E., Hegelmaier, L.M., Abbass, A.A., Barber, J.P., Dekker, J.J., Van, H.L. et al. 482
- drop-outs
  - drop-out rates, research on 479–80
  - from therapeutic process 86–7
- Dryden, W. and Branch, R. 124
- Dryden, Windy 121, 124, 139, 437, 501
- Du Plock, S. 200, 204
- dual relationships, ethics and 462–3
- dualistic view of reality 341
- Dudley, R. and Kuyken, W. 127
- Dueck, A. and Reimer, K. 451
- Duff, C. 367
- Duff, C.T. and Bedi, R.P. 36
- Duffey, T. and Haberstroh, S. 157, 386
- Dumesnil, H. and Verger, P. 513
- Duncan, Barry 78, 287–8
- Duncan, B.L. and Reese, R.J. 79
- Duncan, B.L., Miller, S.D., Sparks, J.A., Claud, D.A., Reynolds, L.R., Brown, J. et al. 43
- Duncan, R.E., Hall, A.C. and Knowles, A. 458
- Dundas, I., Anderssen, N., Wormnes, B. and Hauge, H. 7
- Durlak, J.A. 505
- Durre, L. 464
- Dyche, L. and Zayas, L.H. 352
- dynamic interpersonal theory (DIT) 113

**E**

- early pioneers in
  - psychodynamics 101
- Earth Charter 399
- East Side Institute for Group
  - and Short Term Psychotherapy 227
- eclecticism and integrative
  - therapies 284–5
- ecofeminism 253
- ecological approach 237
  - ecologically informed therapy 403–4
- ecopsychology 253–4
- Edelwich, J. and Brodsky, A. 464–5
- Eells, T.D. and Lombart, K.G. 58
- Eells, T.D., Lombart, K.G., Kendjelic, E.M., Turner, L.C. and Lucas, C.P. 58
- Eells, Tracey 58, 308
- effectiveness
  - of CBT, research on 133
  - research studies 474
  - supervision and 434–5
  - of therapists? 489
- efficacy studies 474
- Egan, Gerard 289–90, 291, 428, 506
- Egan, S.J., Wade, T.D. and Shafran, R. 134
- Egan ‘skilled helper’ model 289–90
- ego 96–7
- Ego, Hunger and Aggression* (Perls, F.) 188
- ego psychology 105
- ego state 174–5
- egosyntonic process 165
- Ehrenreich, B. 519
- Eichenbaum, Luise 381
- Ekers, D., Webster, L., Van Straten, A., Cuijpers, P., Richards, D. and Gilbody, S. 138
- Ekman, P. 273
- Ekroll, V.B. and Ronnestad, M.H. 11
- Elkin, I., Falconnier, L., Martinovich, Z. and Mahoney, C. 489
- Ellenberger, H.F. 323
- Elliott, R. and Friere, E. 155
- Elliott, R. and Partyka, R. 436
- Elliott, R. and Shahar, B. 167
- Elliott, R., Bohart, A.C., Watson, J.C. and Murphy, D. 157
- Elliott, R., Clark, C., Kemeny, V., Wexler, M.M., Mack, C. and Brinkerhoff, J. 167
- Elliott, R., Davis, K. and Slatick, E. 167
- Elliott, R., Greenberg, L.S., Watson, J., Timulak, L. and Freire, E. 169
- Elliott, R., Partyka, R. and Wagner, J. 481, 490
- Elliott, R., Suter, P., Manford, J., Radpour-Markert, L., Siegel-Hinson, R., Layman, C. et al. 167
- Elliott, R., Watson, J., Goldman, R.N. and Greenberg, L.S. 167, 190
- Elliott, Robert 49, 80, 167, 484, 490
- Ellis, Albert 121, 122–3, 137, 138, 187, 326, 388
- Ellis, M.V., Berger, L., Hanus, A.E., Ayala, E.E., Swords, B.A. and Siembor, M. 434
- Ellsworth, L. 289
- Elwyn, G., Barr, P.J. and Grande, S.W. 71
- email counselling and psychotherapy 515
- embedded counselling 507–8
- embodied conversations 270–80
  - agitated movements 274
  - antidepressants, experience of taking 275–6
  - applications 272–5
  - basic concepts 272
  - being in nature 275
  - bodily processes, paying attention to 273–4
  - bodily responses of therapists 274
  - breathing 273
  - discussion topics 279–80
  - ‘embodied attunement’ 277
  - embodied cognition 276
  - embodied therapy, older traditions 271–2
  - experiential focusing 274
  - eye movement
    - desensitisation and reprocessing (EMDR) 274
  - facial expressiveness 273–4
  - facial flushing 274
  - ‘gut brain’ functioning 274
  - healing rituals 271
  - hemispheric
    - functioning 277–8
  - interpersonal
    - neurobiology 278
  - interpersonal
    - synchrony 277
  - lifestyle interventions 275
  - meditation 274
  - mindfulness 274
  - ‘mirror neurons’ 272
  - neurobiological perspective
    - interventions
      - reflecting 274–5
      - risks of uncritical acceptance of 278–9
  - neuroscience
    - advances in 271–2
    - significance of 272, 279
  - outdoor time 275
  - physical movement 275
  - polyvagal theory 276–7
  - psychopharmacology 274–5, 279
  - reading suggestions 280
  - reflection topics 279–80
  - sleep interventions 275
  - specific health conditions, taking account of 275
  - theoretical
    - perspectives 276–8
  - trance states 271
  - trauma theory 276
  - tummy rumbling 274
  - voice quality 273

- embodiment
  - existential therapy 198
  - Gestalt therapy 189
  - therapeutic relationship 39–41
- Emmelkamp, P. 515
- emotion, expression of
  - culturally sensitive therapy 344
  - psychodynamic tradition 99
- emotion-focused therapy (EFT) 166–9
- emotional intelligence, importance of 413–14
- emotional problems, childhood origins of 95–6
- emotions
  - emotional processing 47
  - ethical and moral framework and 452
- ‘empathisers,’ role for 527
- empathy
  - culturally sensitive therapy 352–3
  - ethical and moral framework 451
  - person-centred therapies 156–7
- employee assistance programmes (EAPs) 503
- employee counselling 332
- employment loss, effects of 373
- empowerment, gain of 15
- enactments in family therapy 235
- ending therapy
  - client’s perspective 8–9
  - different types of ending, client’s perspective on 9
  - experience of 84
  - facilitation of process 88
  - impact of ending on therapist 88–9
  - leaving therapy 83–90
  - management of 87–8
  - management of endings, practical strategies for 87–8
  - preparation for ending 87
  - types of ending 85–6
  - unplanned endings 86–7
- engagement
  - in assessment process 189
  - readiness for 53–4
- Englar-Carlson, M. and Kiselica, M.S. 386
- engulfment 206
- enlightenment, gain of 14
- Enns, C.Z. 379
- Enns, C.Z., McNeilly, C.L., Corkery, J.M. and Gilbert, M.S. 460
- entitlements 452–3
- environmental collapse 529
- Epstein, N.B. and Baucom, D.H. 510
- Epston, D. and White, M. 214
- Epston, D., Morris, F. and Maisel, R. 214
- Epston, D., White, M. and Murray, K. 212
- Epston, David 211, 212–13
- Erekson, D., Janis, R., Bailey, R., Cattani, K. and Pedersen, T. 426
- Erickson, Milton H. 222, 232
- Erickson’s contribution to solution-focused therapy 222
- Ericsson, K. Anders 439
- Ericsson, K.A. and Pool, R. 439
- Erikson, Erik 96, 143, 172, 326, 374, 396
- erotic transference 392
- Erskine, R. 166
- Erskine, R.G. and Zalcman, M. 177
- essence in existential therapy 196
- Esterson, A. 381
- Etherington, K. 490
- Etherington, K. and Bridges, N. 9, 87
- ethical and moral
  - framework 445–69
  - 28, 38, 153, 163, 436, 451 451
  - accountability 455–8
  - autonomy of individuals 449, 450
  - beneficence 449–50
- bodily integrity 452
- boundaries, management of 461–7
- boundary violations, sexual misconduct and 465
- brief therapy, ethical concerns in 500
- capabilities
  - perspective 452–3
- care, concept of 453
- case studies
  - ‘duty to protect and warn,’ ethical dilemmas in 456–7
  - Tarasoff case 456–7
- challenge, use of 459–61
- child protection issue 457–8
- client at risk of harming others 456–7
- competence 451
  - working within limits of 461
- confidentiality 455–8
- continuum of client-therapist relationships 463
- courage 451
- cultural differences in ethical values and perspectives 468
- discussion topics 469
- dual relationships 462–3
- emotions 452
- empathy 451
- entitlements 452–3
- Ethical Framework for Counselling Professions (BACP) 451–2
- Ethical Framework for Good Practice (BACP) 451
- ethical guidelines 451–2
- ethical knowledge, sources of 446–54
- ethical principles 449–50
- ethical sensitivity of therapists 411, 412
- ethical standards, strategies for maintenance of 467–8

ethical and moral framework  
     (*Continued*)  
     ethical transgression, rate  
         of 454–5  
     fairness 451  
     false (or recovered)  
         memories 460  
     fidelity, principle of 450  
     general moral theories  
         450–51  
     human rights 452–3  
     humility 451  
     in-session ethical crises,  
         responding to 457  
     individualism, therapist as  
         missionary for 448–9  
     informed consent, action  
         of 459  
     informed consent,  
         negotiation of 458–9  
     integrity 451  
     justice, principle of 450  
     law, ethical issues and 454  
     legal considerations 468  
     moral decision-making  
         450–51  
     moral principles and ethical  
         codes, application  
         of 454–67  
     moral priority 450  
     moral theory  
         practical application  
         of 451  
     multiple relationships  
         462–3  
     non-judgementalism 446,  
         447–8  
     non-maleficence 449  
     organisation-level ethical  
         initiatives 452  
     over-confrontational  
         therapy 460  
     person-centred therapy 453  
         role of therapist in  
         459–60  
     personal intuition 447  
     persuasion, use of 459–61  
     pluralistic therapy, ethical  
         dimension of 301–2  
     practical reason 452  
     process ethics 453–4

psychodynamic therapy,  
     role of therapist  
         in 459–60  
     reading suggestions 469  
     reflection topics 469  
     relational autonomy,  
         principle of 448  
     relational ethics 446,  
         453–4  
     religion and spirituality,  
         ethical issues with 266  
     remote rural community,  
         conduct of therapy with  
         prominent member  
         of 463  
     research on professional  
         ethics 454  
     research on therapy, ethical  
         issues in 467  
     research to inform practice,  
         ethical issues in 491  
     resilience 81, 127, 351, 363,  
         416, 451, 512  
     senses, imagination and  
         thought 452  
     sexual exploitation of  
         clients 464–6  
     sincerity 451  
     social justice  
         orientation 453  
     society as a whole, ethical  
         responsibilities to 458  
     suggestion, use of 459–61  
     therapist sexual behaviour,  
         dynamics of 465  
     touch, ethical issues  
         involved in use of 466–7  
     trauma process, evidence-  
         based models of 460  
     utilitarianism 450  
     values 447–8  
     virtues 450–51  
     wisdom 451  
*Ethics and the Law* (Jenkins, P.)  
     468  
     ethnic client-therapist  
         matching 354–7  
     Eubanks-Carter, C., Muran,  
         J.C. and Safran, J.D. 39  
     European psychodynamic  
         tradition 106

evaluation  
     locus in person-centred  
         therapies of 154  
     of therapy, client's  
         perspective on 9–11  
     Evans, C., Mellor-Clark, J.,  
         Marison, F. 479  
     Evans, M. 266  
     'events paradigm' 486–7  
     Everett, B., MacFarlane, D.A.,  
         Reynolds, V.A. and  
         Anderson, H.D. 463  
     Ewen, V., Mushquash, A.R.,  
         Mushquash, C.J., Bailey,  
         S.K., Haggarty, J.M. and  
         Stones, M.J. 501  
     exception finding 223  
     exceptional therapists,  
         learning from 422–3  
     exclusion from expression 403  
     exercise as cultural  
         resource 313  
     Existential Concerns  
         Questionnaire  
         (ECQ) 199  
*Existential Psychotherapy*  
     (Yalom, I.D.) 203–4  
     existential therapy 195–207  
         agency 198  
         alone-ness 197  
         authenticity 199  
         autonomy 196–7  
         basic principles of 200–202  
         behavioural targets 197  
         being with others 197  
         bracketing rule 201  
         case studies  
             overcoming loss and  
             life-threatening  
             uncertainty 205  
             single-session existential  
             therapy 204  
         client-therapist  
             relationship 200–201  
         death 197–8  
         deep issues, thinking  
             about 195–6  
         depersonalisation 206  
         description rule 201  
         discussion topics 207  
         embodiment 198

- end of time 197–8
- engulfment 206
- essence 196
- existential concerns,
  - measurement of 199
- existential themes 196–9
- ‘existential touchstones’ 206
- freedom 198
- horizontalisation rule 201
- identity 198
- implosion 206
- isolation 196–7
- making sense from
  - existential perspective 201
- meaning 199
- ontological insecurity 206
- parent-child
  - relationship 197
- petrification 206
- phenomenological
  - research 202
- phenonemology and
  - phenomenological approach 201–2
- powerlessness 198
- practice of 204–6
- psychological distress, de-
  - objectification of 203
- reading suggestions 207
- reflection topics 207
- relapse prevention 197
- relatedness 196–7
- schizophrenia (long-term),
  - existential therapy for 205
- sensitivity to questions 196
- sexual difficulties,
  - existential therapy for 205
- techniques in 202–4
- time, living in 197–8
- traditions in 199–200
- truth 199
- ‘way of being’ 201
- Yalom’s ‘missing
  - ingredients’ 203–4
- expansion of counselling,
  - growth factors in 332–3
- expectations, negotiation
  - of 51–2
- experiential focusing
  - case study of 160
  - embodied conversations 274
  - person-centred
    - therapies 159–61
  - use in therapy session, case
    - study of 160
- experimentation 311–12
- expertise, concept of 410
- exposure techniques in
  - CBT 129
- expressive therapy
  - art in therapy and 248
  - person-centred therapy 166
  - toolkit of expressive
    - therapist 247
- extreme situations, learning
  - from 404
- eye movement desensitisation
  - and reprocessing
    - (EMDR) 274
- Eysenck, Hans J. 284–5, 473, 475
- F**
- facial expressiveness 273–4
- facial flushing 274
- Fairbairn, Ronald 104, 105, 107
- fairness, ethics and 451
- ‘faith-adapted’ therapy 263
- Falkenström, F., Grant, J. and
  - Holmqvist, R. 503
- false (or recovered)
  - memories 460
- families, working with 229–39
  - boundaries, significance
    - of 231
  - discussion topics 239
  - family life, structural and
    - systemic aspects of 230
  - feedback, significance of
    - difference in 231
  - homeostatic systems 230–31
  - human systems 230–31
  - life cycle, notion of 231
  - reading suggestions 239
  - reflection topics 239
  - systemic perspective,
    - growth of 229–30
- family therapy
  - case studies
    - family sculpting 236
  - panic attacks, dealing
    - with 237
  - ritual in therapy, use
    - of 237–8
  - change events, use of ritual
    - to create memorable
      - events 238
  - collaboration, use of
    - feedback in promotion
      - of 238
  - collective construction of
    - family reality, Milan
      - group and 232
  - contemporary therapy,
    - common ground in 233
  - conversations in
    - families 232
  - delivery formats for families
    - as clients 511
  - Dialogic Feedback Tool
    - (DFT) 238
  - dialogue, use of feedback in
    - promotion of 238
  - ecological approach 237
  - enactments 235
  - ‘family life, conflict in 415
  - genograms 234–5
  - innovation in 233
  - multi-family therapy 232–3
  - Outcome Rating Scale
    - (ORS) 238
  - patterns across generations,
    - genograms and
      - exploration of 234–5
  - psychoanalytic thinking,
    - influence on 232
  - questioning technique 234
  - reflecting teams 235–6
  - reframing technique 234
  - Session Rating Scale
    - (SRS) 238
  - social ecology of families,
    - initiation of change
      - in 236–7
  - structural therapy 232
  - Systemic Clinical Outcome
    - and Routine Evaluation
      - (SCORE) 238
  - techniques in 234–8
  - theoretical traditions
    - within 231–4



- fantasies  
   use in Gestalt therapy  
     of 189  
     working with 99  
 Farber, B.A. 75, 155  
 Farber, B.A. and Hazanov, V. 432  
 Farber, B.A. and Heifetz, L.J. 441  
 Farber, B.A., Brink, D.C. and Raskin, P.M. 157  
 Farber, B.A., Manevich, I., Metzger, J. and Sappol, E. 415  
 Farnsworth, J.K. and Callahan, J.L. 448  
 Farooq, S., Gahir, M.S., Okyere, E., Sheikh, A.J. and Oyeboode, F. 345  
 Farrell, J.M. and Shaw, I.A. 438  
 Farrell, J.M., Reiss, N. and Shaw, I.A. 138  
 Farrell, N.R. and Deacon, B.J. 492  
 fate, operation of 342  
 Faust, D. and Zlotnick, C. 505  
*FearFighter* 516  
 Federn, Paul 172  
 feedback  
   pluralistic therapy 310  
   significance of difference in 231  
   use in therapeutic process 78–9  
 Feinstein, R.E., Huhn, R. and Yager, J. 428  
 feminism  
   becoming a feminist therapist 385  
   contribution to counselling and psychotherapy 385–6  
   in counselling and psychotherapy, emergence of 381  
   cultural feminism 379  
   feminist ethics, development of 384–5  
   feminist-informed integrationism 381  
   feminist therapy 379–86  
   liberal feminism 379  
 Fennell, M. 131, 517  
 Fenner, P. 40  
 Ferenczi, Sandor 101, 326  
 Fernandez, E., Salem, D., Swift, J.K. and Ramtahal, N. 86  
 Fernández-Álvarez, H. 291, 492  
 Fernández-Álvarez' integrated psychotherapy model 291  
 Ferri, M., Amato, L. and Davoli, M. 508  
 fidelity, principle of 450  
 Fiedler, F.E. 282  
 film in therapy, use of 241, 247  
 financial relationship 43–4  
 Finlay, Linda 202  
 Finn, S.E. and Tonsager, M.E. 54  
 first-person research 491  
 Firth, N., Barkham, M. and Kellett, S. 521  
 Fischer, C.T. 54  
 Fishman, D.B. 303, 490  
 Fishman, D.B., Messer, S.B., Edwards, D.A.J. and Dattilio, F.M. 481  
 first-person language 189  
 Fitzpatrick, M.R. and Stalikas, A. 70  
 fixed role therapy 219  
 Flückiger, C. 312  
 Flückiger, C., Del Re, A.C., Wampold, B.E. and Horvath, A.O. 43, 60  
 flying, help in overcoming fear of 125–6  
 Flyvbjerg, B. 410  
 Fodor, Iris 25  
 Folkes-Skinner, J., Elliott, R. and Wheeler, S. 429  
 Fonagy, P. and Bateman, A.W. 109  
 Fonagy, P., Gergely, G., Jurist, E. and Target, M. 109  
 Fonagy, Peter 107, 108  
 formulation-driven integration 293  
 Fosha, D. 114  
 Foucault, Michel 211, 320, 323  
 Fox, Ragan 9, 37  
 fragile process in person-centred therapies 164–5  
 France, Ann 5  
 Frances, A. 56  
 Frank, J.D. and Frank, J. 14, 59  
 Frank, Jerome 1, 59, 64, 282–3, 288  
 Frankel, S. and Mitchell, C. 457  
 Frankel, Z.E., Holland, J.M. and Currier, J.M. 462  
 Frankl, Victor 200, 206  
 Fransella, F., Dalton, P. and Weselby, G. 219  
 Fransella, Fay 210, 219  
 Franx, G., Oud, M., De Lange, J., Wensing, M. and Grol, R. 522  
 Frayn, D.H. 86  
 Frederick, R.J. 114  
 Fredrickson, B.L. 70  
 free association 99  
 Freedman, J. and Combs, G. 211  
 freedom-control dichotomy 530  
 freedom in existential therapy 198  
 Freire, Paulo 398  
 frequency of sessions 497–8  
 Freud, Anna 98, 105  
 Freud, Sigmund 28–9, 41, 43, 101, 105, 151, 380–81, 496  
   case studies in work of 489  
   contemporary practice, key figure in development of 323–4, 326  
   dream-sharing 370  
   inhumane treatment, resistance against 396  
   integrative therapies and work of 282  
   Oedipal threesome, emotional problems and 110  
   psychodynamic theory, origins of 94–100  
   robust nature of findings 114  
   therapeutic techniques in psychodynamic therapy 97–100

- transference, concept of 97  
 unconscious, importance  
   for 96–7
- Friedberg, R.D. and Wilt,  
 L.H. 131
- Friedlander, M.L., Austin, C.L.  
 and Cabrera, P. 89
- Friedlander, M.L., Lee, H.H.  
 and Bernardi, S. 262
- Friedlander, M.L., Sutherland,  
 O., Sandler, S., Kortz, L.,  
 Bernardi, S., Lee, H.H.  
 et al. 69
- Friedman, D. and Kaslow,  
 N. 421, 433–4
- Friedman, L. 236
- Fromm, Erich 326, 328  
   enduring legacy of 367–8
- Fuhriman, A., Barlow, S.H. and  
 Wanlass, J. 518
- fully functioning person 154
- functional analysis 119
- functional analytic  
   psychotherapy  
   (FAP) 137, 146–8  
   behaviour, awareness (A)  
   courage (C) love (L)  
   model of 147–8  
   case study, FAP in  
   action 148  
   clinically relevant  
   behaviours (CRBs) 146  
   rationale for therapy  
   146–7  
   therapist engagement 147
- future challenges 524–31  
   ‘commons’ concept of 527  
   cultural difference, facing  
   up to 528  
   democratic processes, crisis  
   within 529–30  
   discussion topics 531  
   ‘empathisers,’ role for 527  
   environmental collapse 529  
   freedom-control  
   dichotomy 530  
   future as professions  
   of counselling and  
   psychotherapy 526–8  
   information technology,  
   advances in 526
- new technologies and new  
 types of person 529
- online systems, knowledge  
 availability  
   through 527–8
- person, new types of 529
- political systems,  
 adversarial polarities  
 in 529–30
- professional knowledge,  
 enhanced access  
 to 527–8
- professional services,  
 demand for 526
- ‘psychotechnology’ 329, 530
- reading suggestions 531
- reflection topics 531
- resistance to change 527
- society and therapy,  
 challenges in  
 relationship  
 between 528–30
- status of counselling  
 and psychotherapy  
 as autonomous  
 professions 526, 527
- studies of 525–6
- therapy as social control,  
 danger of 530
- unmet need, pressures  
 of 526–7
- world of counselling  
 and psychotherapy,  
 challenges within 525–6
- The Future of the Professions*  
 (Susskind, R. and  
 Susskind, D.) 526
- G**
- Gabriel, L. 462
- Gabriel, L. and Casemore,  
 R. 453
- GAD self-report scale 478
- Galasiński, D. 477
- Galassi, J.P., Crace, R.K.,  
 Martin, G.A., James,  
 R.M. and Wallace,  
 R.L. 51
- Gale, C. and Schröder, T. 438
- Gale, C., Schröder, T. and  
 Gilbert, P. 438
- Galloway, Janice 518
- games in transactional  
 analysis 176–7  
   gimmick in 177
- Games People Play* (Berne,  
 E.) 176–7
- Garfield, S. 372
- Garfield, S. and Bergin,  
 A.E. 436
- Garrity, M.K. 25
- Gask, Linda 8
- Gassner, Johann Joseph 323
- Gatfield, A. 235
- Gayol, G.N. 179
- Geertz, Clifford 340
- Gega, L., Marks, I. and Metaiz-  
 Cols, D. 516
- Gehart, D.R. and Lyle, R.R. 6
- Geller, J.D. and Farber,  
 B.A. 34, 109
- Geller, J.D., Norcross, J.C. and  
 Orlinsky, D.E. 498
- Geller, Jesse 25, 437
- Geller, S.M. and Greenberg,  
 L.S. 157
- Gelso, C.J. 34
- Gelso, C.J., Kelley, F.A.,  
 Fuertes, J.N.,  
 Marmarosh, C., Holmes,  
 S.E., Costa, C.  
 et al. 34
- Gelso, C.J., Palma, B. and  
 Bhatia, A. 108
- gender and sexuality  
 376–94  
   abusive sexuality 392–3  
   becoming a feminist  
   therapist 385  
   care in relational-cultural  
   therapy 384  
   case study, men’s  
   therapy 387  
   client experiences 377  
   connectedness in relational-  
   cultural therapy, theme  
   of 383  
   counselling skills, therapist  
   use of 378  
   cultural feminism 379  
   depression, feminist  
   approach to 384

- gender and sexuality  
     (*Continued*)  
     discussion topics 393–4  
     erotic transference 392  
     exploitation of women 380  
     feminism, contribution  
         to counselling and  
         psychotherapy 385–6  
     feminist counselling  
         and psychotherapy,  
         emergence of 381  
     feminist ethics, for practice,  
         development of  
         384–5  
     feminist-informed  
         integrationism 381  
     feminist therapy 379–86  
     gender and sexual  
         diversity 387–90  
     gender and sexually diverse  
         people, experiences in  
         therapy of 389–90  
     gender competence of  
         therapists 378  
     gender-informed  
         approaches to  
         therapy 379–90  
     gender relationships,  
         culturally sensitive  
         therapy and 344  
     heterosexual men, therapy  
         for 386–7  
     internalisation of the  
         therapist 377  
     interventions, effectiveness  
         of 378  
     LGBTQ+ (lesbian, gay,  
         bisexual, transgender,  
         intersex, queer,  
         questioning, BDSM/  
         Kink, nonbinary,  
         asexual, consensual  
         non-monogamous,  
         and other diverse  
         sexualities and  
         practices) 387–8  
     liberal feminism 379  
     negative attitudes of  
         therapists to gender  
         and sexual  
         diversity 390  
     negative social attitudes  
         to LGBT community,  
         dealing with 388–9  
     painful experiences,  
         disclosure of 377–8  
     penis envy hypothesis  
         380–81  
     psychotherapy, feminist  
         critique of 380–81  
     radical feminism 379  
     reading suggestions 394  
     reflection topics 393–4  
     relational-cultural  
         therapy 382–4  
     Sexual and Marital Therapy  
         (journal) 391  
     sexual concerns, therapy  
         for 390–92  
         talking about sexual  
         concerns, difficulties  
         in 391–2  
     sexual diversity, gender  
         and 387–90  
     socialist feminism 379  
     substance abuse,  
         feminist-informed  
         integrationism and  
         working with 382  
     therapeutic significance of  
         gender 377–8  
     therapy, feminist approach  
         to 379  
     women's development,  
         relational nature of 383  
     Gendlin, Eugene 152, 157, 158,  
         159, 160  
     general anxiety disorder  
         (GAD) 262  
     generations, patterns across,  
         genograms and  
         exploration of 234–5  
     genograms 234–5  
     Gergen, K.J. 210, 214, 225, 399  
     Gergen, K.J. and Kaye, J. 214  
     Geronimus, A.T. 366  
     Gestalt therapy 185–94  
         application of, emerging  
         areas of 192–3  
         awareness and change,  
         strategies for  
         facilitation of 189–91  
         case studies  
             ‘Gloria’ tapes of  
                 sequential therapy  
                 sessions 188  
             ‘Irvina’ contemporary  
                 practice in case  
                 of 190–91  
             ‘Rose’ case report 188  
         combination with  
             other therapeutic  
             approaches? 193  
         contact, concept of 189  
         cultural and philosophical  
         influences 185–7  
         deflection 189  
         discovery, process of 189  
         discussion topics 194  
         dream imagery, use of 189  
         embodiment 189  
         engagement in assessment  
         process 189  
         fantasy, use of 189  
         first-person language 189  
         introjection 189  
         isolation 189  
         Perls’ interests and values  
             in 186, 188  
         polarities 189  
         practice, theoretical  
             framework for 188  
         process and outcome of,  
         research into 191–2  
         projection 189  
         psychoanalytic origins  
             of 186–7  
         reading suggestions 194  
         reflection topics 194  
         retroflexion 189  
         two-chair work 190,  
             191–2  
     *Gestalt Therapy* (Perls, F.S.,  
         Hefferline, R.F. and  
         Goodman, P.) 188  
     Gibson, K. and Cartwright,  
         C. 10, 162, 488, 516  
     Giddens, Anthony 321  
     Gilbert, P. 131, 138  
     Gilbert, P. and Leahy, R.L. 125  
     Gillard, S., Gibson, S.L., Holley,  
         J. and Lucock, M. 509  
     Gilligan, C. 382

- Gingerich, W.J. and Peterson, L.T. 225
- Gladding, S.T. and Wallace, M. 37
- Glass, L.L. 41–2
- Glasser, William 289, 291
- Glickauf-Hughes, C. and Mehlman, E. 418
- globalisation of therapy 260
- goals
- agreement on 57
  - insight, aim of 98
  - shared understanding of 306
- Goffman, Erving 177
- Gold, E. and Zahm, S. 191
- Gold, Jerry 294
- Goldberg, C. and Simon, J. 71
- Goldberg, D.P., Hobson, R.F., Maguire, G.P., Margison, F.R., O'Dowd, T., Osborn, M.S. et al. 111
- Goldberg, S.B. and Sachter, L.D. 437
- Goldberg, S.B., Babins-Wagner, R., Rousmaniere, T., Berzins, S., Hoyt, W.T., Whipple, J.L. et al. 504
- Goldfried, M.R. 25, 64, 155
- Goldfried, M.R., Raue, P.J. and Castonguay, L.G. 423
- Goldilocks Effect 81
- Goldman, R.N. and Greenberg, L.S. 168
- Goldman, R.N., Greenberg, L.S. and Angus, L. 169
- Goldsmith, J.Z., Mosher, J.K., Stiles, W.B. and Greenberg, L.S. 68
- Golkaramnay, V., Bauer, S., Haug, S., Wolf, M. and Kordy, H. 516
- Gomez, L. 97, 101
- Gompertz, W. 249
- Gonçalves, M. M., Mendes, I., Cruz, G., Ribeiro, A. P., Sousa, I., Angus, L. et al. 218
- Gonçalves, M.M., Matos, M. and Santos, A. 70
- Gonçalves, M.M., Ribeiro, A.P., Mendes, I., Matos, M. and Santos, A. 218
- Gonyea, J.L., Wright, D.W. and Earl-Kulkosky, T. 462
- González-Hidalgo, M. 192
- Goode, J., Park, J., Parkin, S., Tompkins, K.A. and Swift, J.K. 88
- Goodman, L.A., Liang, B., Helms, J.E., Latta, R.E., Sparks, E. and Weintraub, R. 396–7, 402
- Goodman, L.A., Pugach, M., kolnik, A. and Smith, L. 399
- Goodman, L.A., Wilson, J.M., Helms, J.E., Greenstein, N. and Medzhitova, J. 399, 400–401
- Goodman, Paul 40, 185, 186
- Goodman, R.D. 235
- Göstas, M.W., Wiberg, B., Neander, K. and Kjellin, L. 6, 7, 64
- Goulding, Bob and Mary 179–80
- Grafanaki, S. and McLeod, J. 157, 164
- Grant, J. 78
- Grawe, Klaus 472
- Gray, Dr. Herbert 331
- Gray, L.A., Ladany, N., Walker, J.A. and Ancis, J.R. 434
- Great Leap Forward (Mao, 1958–1963) 528
- Greenberg, Les 56, 167, 190, 191–2, 271
- Greenberg, L.S. and Goldman, R.N. 510
- Greenberg, L.S. and Johnson, S. 167
- Greenberg, L.S. and Pinsof, W.M. 485
- Greenberg, L.S. and Watson, J.C. 167
- Greenberg, L.S., Elliott, R. and Foerster, F.S. 167
- Greenberg, L.S., Rice, L.N. and Elliott, R. 23, 63, 167
- Greenberg, L.S., Watson, J.C. and Lietaer, G. 193
- Greenberg, R.P., Constantino, M.J. and Bruce, N. 51
- Greenberger, D. and Padesky, C.A. 131, 517
- Greene, G. 182
- Greenway, R. 254
- Greer, Germaine 380
- Grencavage, L.M. and Norcross, J.C. 283
- Grime, P.R. 131, 516
- Grof, Stanislav 264
- Gross, B. and Elliott, R. 164
- Grossman, F. K., Sorsoli, L. and Kia-Keating, M. 7, 10
- Grumet, G.W. 514
- Gualano, M.R., Bert, F., Martorana, M., Voglino, G., Andriolo, V., Thomas, R. et al. 519
- Guantanamo Bay Detainment Camp 458
- Guay, S., O'Connor, K.P., Gareau, D. and Todorov, C. 131, 132
- Guerry, J.D. 431
- Guggenbuhl-Craig, A. 416
- Guiffrida, D.A., Douthit, K.Z., Lynch, M.F. and Mackie, K.L. 483
- Gurdjieff, George 264
- Gurman, A.S., Lebow, J.L. and Snyder, D.K. 510
- Gutheil, T. and Gabbard, G. 41, 461
- Guthrie, E. 112
- Guthrie, E., Kapur, N. and Mackway-Jones, K. 112
- Guttman, H.A. 230
- Guy, J.D. 415
- Gyani, A., Shafran, R. and Myles, P. 492
- Gyani, A., Shafran, R., Rose, S. and Lee, M.J. 492

## H

- Haaga, D.A. 520
- Haarakangas, K., Seikkula, J., Alakare, B. and Aaltonen, J. 225, 226

- Haas, E., Hill, R.D., Lambert, M.J. and Morrell, B. 60
- Hage, S.M., Romano, J.L., Conyne, R.K., Kenny, M., Matthews, C., Schwartz, J.P. et al. 513
- Halewood, A. and Tribe, R. 417, 418
- Haley, Jay 222, 232
- Halgin, R.P. and Caron, M. 54
- Hall, E., Hall, C., Stradling, P. and Young, D. 23
- Hallett, C., Klug, G., Lauber, C. and Priebe, S. 506
- Halling, S., Leifer, M. and Rowe, J.O. 202
- Halling, Steen 202
- Halmos, P. 325
- Halpern, D. 312, 365
- Halvorsen, M.S., Benum, K., Haavind, H. and McLeod, J. 71
- Hamm, J.A. and Leonhardt, B.L. 89
- Handelsman, M.M. and Galvin, M.D. 459
- Hanna, F.J. and Puhakka, K. 60, 71
- Hansen, B. P., Lambert, M. J. and Vlass, E. N. 423
- Hansen, J.T. 303, 412, 420
- Hansen, N. B., Lambert, M. J. and Forman, E. M. 499
- Hanson, J. 75
- Harding-Davies, V., Hunt, K., Alred, G. and Davies, G. 429
- Hardy, G. E., Barkham, M., Shapiro, D. A., Reynolds, S., Rees, A. and Stiles, W. B. 51
- Hardy, G. E., Bishop-Edwards, L., Chambers, E., Connell, J., Dent-Brown, K., Kothari, et al 484
- Harford, D. 182
- Harford, D. Widdowson, M. 182
- Hargaden, Helena 180, 182–3
- Harman, Bob 188
- harmful therapy, issue of 484
- Harris, R. 109
- Hartanto, D., Kampmann, I. L., orina, N., Emmelkamp, G., Neerincx, M. and rinkman, W. P. 516
- Hartford, G. 254
- Hartmann, E. 41
- Harvey, David 329
- Harway, M. 510
- Haskayne, D., Larkin, M. and Hirschfeld, R. 7, 114
- Hatcher, R.L and Gillaspay, J.A. 486
- Hatfield, D., McCullough, L., Frantz, S. H. B. and Krieger, K. 78, 484
- Hattie, J. A., Sharpley, C. F. and Rogers, H. J. 505
- Hawkins, P. and Shohet, R. 432, 433
- Hayashi, S., Kuno, T., Morotomi, Y., Osawa, M., Shimizu, M. and Suetake, Y. 161
- Hayes, J.A. 412
- Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A. and Lillis, J. 135–6
- Hayes, S. C., Strosahl, K. and Wilson, K. 136, 137
- Hayes, S. C., Villatte, M., Levin, M. and Hildebrandt, M. 137
- Hayes, S.C. 25
- Haynes, S. N., O'Brien, W. H., Keaweaimoku, J. and Witteman, C. 49, 119, 120, 135
- Hazleden, R. 519
- healing
- healing lament in Finland 347–8
  - healing rituals 271
  - theory of 344
- healing practices
- culturally diversity in 346–9
  - implications in cultural diversity of 349
- Hearing Voices network 508
- Hecker, L.L. and Deacon, S.A. 23
- Hecker, L.L., C.F. and Sori 23
- Hefferline, Ralph 185
- Hegarty, T., Smith, G. and Hammersley, M. 216
- Heidegger, Martin 196, 201
- Heimann, P. 105
- Hellman, I.D. and Morrison, T.L. 441
- Helms, J. 350
- helpfulness
- client perceptions of 73–4
  - micro-analysis of 72–3
- hemispheric functioning 277–8
- Henderson, K.L. 458
- Henkelman, J. and Paulson, B. 75
- Henretty, J. R., Currier, J. M., Berman, J. S. and Levitt, H. M. 75
- Henretty, J.R. and Levitt, H.M. 75
- Henry, W.E. 415
- Hermansson, G. 461
- Hermens, M. L. M., Muntingh, A., Franx, G., van Splunteren, P. T. and Nuyen, J. 522
- Herrera, P., Mstibovskiy, I., Roubal, J. and Brownell, P. 192
- Herron, W.G. and Sitkowski, S. 44
- Hersoug, A. G., Hoglend, P., Havik, O., von der Lippe, A. and Monsen, J. 418
- Hess, S. A., Knox, S. and Hill, C. E. 431
- Hesse, E. 108
- heterosexual men, therapy for 386–7
- Higley, N. and Milton, M. 253
- hikikomori*, culture-bound syndrome of 346
- Hill, C. E., Baumann, E., Shafran, N., Gupta, S., Morrison, A., Rojas, A. et al. 426–7
- Hill, C. E., Gelso, C. J., Chui, H., Spangler, P. T., Hummel, A., Huang, T. et al. 21



- Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J. and Rhodes, R. H. 77
- Hill, C. E., Sim, W., Spangler, P., Stahl, J., Sullivan, C. and Teyber, E. 72, 490
- Hill, C. E., Spiegel, S. B., Hoffman, M. A., Kivlighan, D. M., Jr. and Gelso, C. J. 410
- Hill, C.E. and Knox, S. 75
- Hill, C.E. and Lent, R.W. 428
- Hill, C.E. and Nakayama, E.Y. 155
- Hill, Clara E. 20, 23, 155, 200, 221, 283, 428, 437, 490
- Hilsenroth, M.J. and Cromer, T.D. 54, 55
- Hinshelwood, R.D. 53
- Hirai, M. and Clum, G.A. 519
- Hirschhorn, L. 503
- historical context of  
     contemporary practice 319–37  
     American Personnel and Guidance Association (APGA) 331  
     ‘asylums,’ development of 322  
     British Association for Counselling and Psychotherapy (BACP) 333  
     care of insane people, debates about 322–3  
     ‘coaching,’ concept of 334  
     counselling  
         emergence of 330–33  
         psychological therapies and, demand for 334–5  
         psychotherapy and, critical perspectives on role of 324  
     cultural construction of psychotherapy 336  
     cultural themes, development of practice and 336  
     ‘demonology’ 322  
     discussion topics 337  
     employee counselling 332  
     expansion of counselling, growth factors in 332–3  
     historical origins of counselling and psychotherapy 320–21  
     hypnosis 323–4  
     Improving Access to Psychological Therapies (IAPT) 329  
     Industrial Revolution, effects of 320–21  
     insanity, medical and biological explanations for 322  
     interpersonal therapies, historical roots of 142–3  
     knowledge, shift in type informing practice 328–9  
     modern world, dilemmas of 321  
     ‘moral panic’ within society, counselling and 331  
     mutualism, philosophy of 331  
     neoliberalism, effects of 328–9  
     Pelmanism 330  
     personal troubles, multiplicity of ways of making sense of 336  
     phrenology 322  
     political context, influences of 328–9  
     professional identities, emergence of other identities 333–5  
     psychiatry as medical specialism, establishment of 321–3  
     psychoanalysis 323–4  
         in US, Freud and 326  
     psychotherapeutic help, providers of 334–5  
     psychotherapy  
         coming of age in US of 325–8  
         emergence of 321–30  
         recent history of 328–30  
         reading suggestions 337  
         reflection topics 337  
         RELATE in Britain 331–2  
         research to inform practice, historical development of 472–4  
         Rogers, pivotal role of Carl 327  
         Second World War, effects of 326–7  
         social change, reshaping therapy in response to 329–30  
         social construction of psychotherapy 336  
         social origins of counselling and psychotherapy 320–21  
         social structures in US, social mobility and erosion of 325–6  
         society, counselling and psychotherapy within 335–6  
         traditional cultures 321  
         transcultural history of therapy, looking towards 335  
         Vocation Bureau 331  
         vocational choice inventories 334  
         Western society, nature of change in 320  
         workplace structures, fundamental transformation of 321
- Hobfoll, S.E. 312
- Hobson, Bob 37, 111
- Hoener, C., Stiles, W. R., Luka, B. J. and Gordon, R. A. 162
- Hoffman, L. 214
- Hofmann, L. and Walach, H. 261, 266
- Hofmann, S. G., Sawyer, A. T. and Fang, A. 139
- Hogan, S. 240
- Høigaarda, R. and Mathisen, P. 507

- Holland, S. 351–2, 399  
 Holma, J., Partanen, T., Wahlstrom, J., Laitila, A. and Seikkula, J. 448  
 Holmes, Jeremy 40, 109  
 Holmes, S.E. and Kivlighan, D.M. 511  
 Holroyd, J.C. and Brodsky, A. 464  
 Holtzman, B.L. 464, 465  
 Holzman, L. and Mendez, R. 227  
 Holzman, Lois 227  
 homeostatic systems 230–31  
 homework  
   cognitive-behavioural therapy (CBT) and 130  
   tasks for, exploring resources and 223–4  
 Honos-Webb, L. and Stiles, W.B. 17, 68  
 Honos-Webb, L., Stiles, W. B., Greenberg, L. S. and Goldman, R. 67, 68  
 hope as common factor in integrative therapies 288  
 horizontalisation rule in existential therapy 201  
 Horney, Karen 186  
 horticulture therapy 255–6  
 Horvath, A.O. and Greenberg, L.S. 42, 486  
 Hoshmand, L.T. and O'Byrne, K. 483  
 Hospital Anxiety and Depression Scale (HADS) 476–7  
 House, R. 5  
 Howard, G. S., Nance, D. W. and Myers, P. 32  
 Howard, K. I., Krause, M. S., Caburney, C. A. and Noel, S. B. 482  
 Howell, E. 379, 380  
 Hoyt, M. F., Bobele, M., Slive, A., Young, J. and Talmon, M. 501–2  
 Hoyt, M.F. and Talmon, M. 502  
 Hsu, J. 347  
 Hsuan-Ying, H. 528  
 Hubble, Mark 287–8  
 Huber, H. and Klug, G. 498  
 human quality in therapeutic process 47  
 human rights 452–3  
 human systems 230–31  
 human trafficking, responding to victims of 402  
 humanistic counselling 169  
 humanistic therapies 165–9  
   philosophical and cultural underpinning of 151–2  
 humiliation, undoing effect of 368–9  
 humility  
   culturally sensitive therapy 352–3  
   ethical and moral framework 451  
 Hunsley, J., Aubry, T. D., Verservelt, C. M. and Vito, D. 8, 85  
 Hunter, M. and Struve, J. 466  
 Husserl, Edmund 201  
 Hycner, R. and Jacobs, L. 188  
 Hymmen, P., Stalker, C. A. and Cait, C. A. 501  
 hypnosis 323–4  
**I**  
 Iarussi, M.M. and Shaw, B.M. 54  
 Ibrahim, F.A. and Heuer, J.R. 350, 396  
 id in psychodynamic tradition 96–7  
 identity in existential therapy 198  
*The Illness Narratives* (Kleinman, A.) 352  
 imagery rescripting in CBT 129–30  
 images of therapeutic relationship, reflection on 33–4  
 impass resolution 76–8  
 implosion in existential therapy 206  
 Improving Access to Psychological Therapies (IAPT) initiative 329  
   delivery formats for better access and effect 504, 521  
   psychodynamic tradition and 113  
 Improving Access to Psychological Therapies (IAPT) programme 113, 329, 480, 521  
 individualism  
   individualistic self 342  
   therapist as missionary for 448–9  
 individuals as clients 509–10  
 individuation, gain of 14  
 Industrial Revolution, effects of 320–21  
 inequality, social concerns of 366  
 information  
   information collecting 284  
   information technology, advances in 526  
   provision of 306  
 informed consent  
   action on 459  
   negotiation of 458–9  
   pluralistic therapy 306  
   therapeutic process 51  
 Ingham, C. 517  
 Ingold, Tim 339  
 inner critic 162–3  
 innovation  
   in family therapy 233  
   innovative moments 70  
 insanity, medical and biological explanations for 322  
 insecure-ambivalent attachment 107–8  
 insecure-avoidant attachment 107–8  
 insecure-disoriented attachment 107–8  
 insight  
   aim of 98  
   gain of 14  
 institutions 442  
 integrative therapies 281–98

- 'adapted' approaches to therapy 296–7
- assimilative integration 294
- case study, symptom-oriented *vs.* person-oriented approaches 291–2
- choice, reality therapy and concept of 289
- cognitive analytic therapy (CAT) 290
- collective integration 296
- combination, trend towards 297–8
- common factors, contextual model and 287–8
- common factors perspective 283, 287–8
- common language for therapy 295–6
- context, confusions of 284–5
- discussion topics 298
- disorder-based integrative approaches 293
- eclecticism and 284–5
- Egan 'skilled helper' model 289–90
- Fernández-Álvarez' integrated psychotherapy model 291
- formulation-driven integration 293
- hope as common factor 288
- information collecting 284
- integrated *vs.* 'pure' approaches, debate about 284–5
- integrative models of therapeutic relationship 31–4
- Lazarus' multimodal therapy model 286
- limits of therapy based on single approach 287
- meta-theoretical integration 293
- modular integration 292
- movement towards integration 283–4
- non-specific therapeutic factors perspective 283
- partial integrations 291
- permeability of therapy traditions 295
- personal integration 293–4
- Persuasion and Healing (Frank, J.) 282–3
- phased integration 292
- pluralism 296
- principle-driven integration 294–5
- problem management, concept of 289–90
- reality therapy 289
- reflection on 291
- reflection topics 298
- strategies for achievement of integration 285–97
- systematic treatment selection 286
- technical eclecticism 285–6
  - advantages of 286
- theoretical integration, integrated approaches 288–91
- theories of therapy, similarities across 282–3
- unified psychotherapy 295
- integrity 451
- intellectual curiosity 472–3
- intensity 70–71
- intentionality 49
- interactive drawing therapy (IDT) 242
- intermittent therapy 500–501
- internal conflicts, dealing with 67–8
- International Classification of Diseases (ICD) 56
- International Transactional Analysis Association (ITAA) 181
- Internet technologies 514–17
- interpersonal
  - neurobiology 278
- interpersonal process of starting therapy 59–60
- interpersonal process recall (IPR) 80
- interpersonal psychotherapy (IPT) 143–6
  - case formulation 144
  - case study, IPT in action 145–6
  - decision analysis 145
  - delivery of 144
  - implementation in non-Western contexts 145
  - pragmatic rationale for client problems 144–5
  - role-play 145
  - structure of 144
  - techniques and interventions 144, 145
- interpersonal skills
  - counselling and 428–9
  - pluralistic therapy 309
  - qualities of effective therapists 411, 412–13
- interpersonal synchrony 277
- interpersonal therapies 142–9
  - discussion topics 149
  - functional analytic psychotherapy (FAP) 146–8
    - behaviour, awareness (A) courage (C) love (L) model of 147–8
  - case study, FAP in action 148
  - clinically relevant behaviours (CRBs) 146
  - rationale for therapy 146–7
  - therapist engagement 147
- historical roots of 142–3
- interpersonal psychotherapy (IPT) 143–6
  - case formulation 144
  - case study, IPT in action 145–6
  - decision analysis 145
  - delivery of 144
  - implementation in non-Western contexts 145
  - pragmatic rationale for client problems 144–5

- interpersonal therapies  
     (*Continued*)  
     role-play 145  
     structure of 144  
     techniques and  
         interventions 144, 145  
     reading suggestions 149  
     reflection topics 149  
 interpretation 99–100  
 intersectionality 350–51  
 intervention  
     effectiveness of 378  
     existing therapy  
         interventions, use  
         of 311  
     focus in CBT on 125  
     lifestyle interventions 275  
     strategies for, application of  
         techniques 128–31  
     techniques for 22–4  
 introjection in Gestalt  
     therapy 189  
 ‘irrational beliefs’ 122–3  
 irritable bowel syndrome  
     (IBS) 112  
 isolation  
     existential therapy 196–7  
     Gestalt therapy 189  
 Itten, T. and Young, C. 205  
 Ivey, A.E. 81  
 Ivey, A.E. and Galvin, M. 428  
 Ivey, G. and Phillips, L. 436–7
- J**  
 Jackson, Don 40, 232  
 Jacobs, A. 106  
 Jacobs, E. E., Masson, R. L.  
     and Harvill, R. L. 511  
 Jacobs, M. 180  
 Jacobson, N. C., Newman, M. G.  
     and Goldfried, M.  
     R. 134, 491  
 Jacobson, N. S., Martell, C. R.  
     and Dimidjian, S. 138  
 James, M. and Jongeward,  
     D. 193  
 James, William 301, 326  
 Jamison, Kay 518  
 Janet, Pierre 323  
 Jedlicka, D. 235  
 Jeffers, S. 517
- Jennings, L. and Skovholt,  
     T.M. 422, 423  
 Jennings, L., Sovereign, A.,  
     Bottorff, N., Mussell,  
     M. P. and Vye, C. 448, 453  
 Johansson, R., Ekbladh, S.,  
     Hebert, A., Lindström,  
     M., Möller, S., Petitt, E.  
     et al. 114  
 Johansson, R., Frederick, R. J.  
     and Andersson, G. 114  
 Johnson, A.J. 510  
 Johnson, D.R. 389  
 Johnstone, L. 56, 518  
 Johnstone, L. and Boyle,  
     M. 56, 57  
 Johnstone, L. and Dallos, R. 58  
 Joines, C. and Stewart, I. 57, 173  
 Jones, Ernest 22, 41, 104, 110,  
     418  
 Jordan, M. and Marshall,  
     H. 256–7  
 Jordan, Martin 382–3, 403  
 Jorm, A. F., Griffiths, K.M. and  
     Christensen, H. 519  
 Jorm, A. F., Medway, J.,  
     Christensen, H., Korten,  
     A. E., Jacomb, P. A. and  
     Rodgers, B. 4  
 Joseph, Stephen 165  
 Josselson, R. 28, 32–3  
 Josselson's multi-dimensional  
     model 32–3  
 Jourard, Sidney 151  
*Journal of Mind and  
     Behaviour* 301  
 journaling 437  
 Jung, Carl Gustav 41, 101, 264,  
     265, 326, 328, 370  
 Jupp, J.J. and Shaul, V. 441  
 Just Therapy Team in New  
     Zealand 358, 398–9
- justice  
     concept of 398  
     principle of 450  
     *see also* social justice  
     orientation
- K**  
 Kabat-Zinn, Jon 130  
 Kaberry, S. 434
- Kächele, H. 486  
 Kächele, H., Erhardt, I.,  
     Seybert, C. and  
     Buchholz, M. B. 486  
 Kächele, H., Richter, R.,  
     Thoma, H. and  
     Meyer, A.-E. 106  
 Kadooka, Y., Okita, T. and  
     Asai, A. 457  
 Kagan, N. 80, 487  
 Kagan, N. and Kagan, H. 80  
 Kagan, N., Krathwohl, D. R.  
     and Miller, R. 80, 428  
 Kahlon, S., Neal, A. and  
     Patterson, T. G. 58  
 Kahn, E. 158  
 Kampmann, I. L., Emmelkamp,  
     P. M., Hartanto, D.,  
     Brinkman, W. P.,  
     Zijlstra, B. J.  
     and Morina, N. 516  
 Kannan, D., Henretty, J. R.,  
     Piazza-Bonin, E., Levitt,  
     H. M., Coleman, R. A.  
     et al. 79  
 Kant, Immanuel 450, 451  
 Kanter, J. 143  
 Kanter, J., Tsai, M. and  
     Kohlenberg, R. 137, 146  
 Kaplan, A. 89, 382  
 Kaplowitz, M.J., Safran, J.D.  
     and Muran, C.J. 413–14  
 Kareem, J. 352, 429  
 Karlsruher, A.E. 505  
*karma*, Hindu notion of 342  
 Karpman, S. 177  
 Kasper, L., Hill, C.E. and  
     Kivlighan, D.M.,  
     Jr. 72–3, 490  
 Kastrani, T., Deliyanni-  
     Kouimtzi, V. and  
     Athanasiaides, C. 6  
 Kauffman, K. and New, C. 509  
 Kazantzis, N. and L'Abate, L. 66  
 Kazantzis, N., McEwan, J. and  
     Dattilio, F. M. 130  
 Kazantzis, N., Whittington, C.  
     and Dattilio, F. 66  
 Kazdin, A.E. 117, 374, 477, 480  
 Kehoe, L.E., Hassen, S.C. and  
     Sandage, S.J. 504

- Keith-Spiegel, P. 463  
Kellogg, S. 190  
Kelly, E.W. 447  
Kelly, George 219  
Kendjelic, E.M. and  
Eells, T.D. 58  
Kennard, D. 509  
Kennedy, B.S.A. and  
Black, T.G. 25  
Kennerley, H. 131  
Kennerley, H., Kirk, J. and  
Westbrook, D. 126, 133  
Kernberg, O.F. 105  
Kerner, E. and Fitzpatrick,  
M. 244–5  
Khazaie, H., Rezaie, L.,  
Shahdipour, N. and  
Weaver, P. 86  
Khele, S., Symons, C. and  
Wheeler, S. 454  
Kidd, S.A. and Kral, M.J. 483  
Kierkegaard, Søren 196  
Kiesler, D. 38, 310  
Kim, D.-M., Walmpold, B. E.  
and Bolt, D. M. 489  
Kim, J.S., Brook, J. and  
Akin, B.A. 225  
King, A. 23  
kinship patterns 344  
Kira, I.A. and Tummala-Narra,  
P. 528  
Kirsch, T.B. 322, 436  
Kirschenbaum, H. 152, 327, 448  
Kitchener, B.A. and  
Jorm, A.F. 513  
Kitchener, K.S. 450  
Kivlighan, D.M., III, Goldberg,  
S.B., Abbas, M., Pace,  
B.T., Yulish, N.E.,  
Thomas, J.G.  
et al. 114  
Kivlighan, D.M., Jr. 38, 50, 310  
Klein, Melanie 101–3, 104–5,  
107, 166  
Klein, M.H., Mathieu-Coughlan,  
P. and Kiesler, D.J. 152,  
159, 164  
Kleinman, A. 352  
Klerman, Gerald 143  
Knapp, S., Gottlieb, M.C. and  
Handelsman, M.M. 435  
knowledge  
shift in type informing  
practice 328–9  
ways of knowing 302  
Knox, R. and Cooper, M. 163  
Knox, R., Murphy, D., Wiggins,  
S. and Cooper, M. 35,  
163  
Knox, S., Adrians, N., Everson,  
E., Hess, S., Hill, C. and  
Crook-Lyon, R. 9, 84  
Knox, S. and Hill, C.E. 75  
Knox, S., Goldberg, J.L.,  
Woodhouse, S.S. and  
Hill, C.E. 10, 34  
Knudson-Martin, C. 109  
Koffka, K. 186  
Kohlenberg, Robert 146  
Kohler, W. 186  
Kohon, G. 105, 324  
Kohut, Heinz 105  
Kolmes, K. and Taube, D.O. 461  
Kolts, R.L., Bell, T., Bennett-  
Levy, J. and Irons,  
C. 438  
Kolts, R.L., Hayes, S.C. and  
Gilbert, P. 138  
Kondratyuk, N. and  
Peräkylä, A. 203  
Koole, S.L., Greenberg, J. and  
Psyzezynski, T. 196  
Kopp, R.R. 221  
Kopp, R.R. and Craw, M.J. 221  
Kort, J. 389  
Kottler, J.A. 44, 442  
Kottler, J.A. and Carlson, J. 77  
Kovel, J. 325  
Kozan, S. and Blustein,  
D.L. 400–401  
Kraepelin, Emil 322  
Kramer, U. and Stiles, W.B. 17  
Kraus, D.R., Castonguay, L.,  
Boswell, J.F., Nordberg,  
S.S. and Hayes,  
J.A. 410, 489  
Kravariti, E., Reeve-Mates,  
C., Pires, R. D. G.,  
Tsakanikos, E., Hayes,  
D., Renshaw, S. et al. 87  
Kress, V. E., O'Neill, R. M.,  
Protivnak, J. J., Stargell,  
N. A. and Herman, E.  
R. 468  
Krietemeyer, B. and  
Prouty, G. 166  
Kuenzli, F. 190–91  
Kuerbis, A., Houser, J.,  
Levak, S., Shao, S. and  
Morgenstern, J. 158  
Kuhnlein, I. 10, 480  
Kurioka, S., Muto, T. and  
Tarumi, K. 515  
Kurri, K. and Wahlström, J. 50,  
448  
Kurtz, R. and Grummon, D. 156  
Kvale, S. 211  
Kyriakopoulos, A. 254
- L**  
La Roche, M.J. 359  
Lacan, Jacques 106, 222  
Lafrance Robinson, A.,  
McCague, E. A. and  
Whissell, C. 168  
Lago, C. and Charura, D. 161  
Lahad, Mooli 286, 432  
Laing, R. D., Phillipson, H. and  
Lee, A. R. 38  
Laing, R.D. 106, 143, 200,  
205, 206  
Laireiter, A.-R. and Willutzki,  
U. 436  
Lamb, D.H. and Catanzaro,  
S.J. 462, 463  
Lambert, J.E. and Alhassoon,  
O.M. 528  
Lambert, Michael J. 78, 79, 500  
Lambert, M.J. and Ogles,  
B.M. 75, 426  
Lampropoulos, G.K. 64  
Landes, S. J., Kanter, J. W.,  
Weeks, C. E. and Busch,  
A. M. 148  
Landrine, H. 342, 344  
Laney, C. and Loftus, E.F. 460  
Langdrige, D. 389  
Langley, D. 246  
language  
narrative approaches and  
use of 209, 222  
sensitivity to use of 307  
significance of 349–50



- Larance, L.Y. and Porter, M.L. 365
- Larkings, J.S., Brown, P.M. and Scholz, B. 50
- Larsen, D.J. and Stege, R. 60
- Lasky, R. 436
- Laszloffy, T.A. 404
- Lauka, J.D., Remley, T.P. and Ward, C. 461
- Lavik, K.O., Froyisa, H., Brattebo, K.F., McLeod, J. and Moltu, C. 59
- law
- ethical issues and 454
  - legal considerations 468
- Law, D. and Cooper, M. 57
- Law, D. and Jacob, J. 57
- Lawn, S., Delany, T., Pulvirenti, M., Smith, A. and McMillan, J. 73
- Lawrence, W.G. 370
- Lawson, G. 441
- Lazarus, Arnold A. 31, 155, 285–6
- Lazarus' multimodal therapy model 286
- Leahy, R. 23
- learning
- change in therapy and 64–71
  - facilitation of 310–12
  - outcomes of, therapist's perspective 14
- Leaviss, J. and Uttley, L. 138
- Lebow, J. 436
- Ledley, D.R., Marx, B.P. and Heimberg, R.G. 126
- Lee, A. 179
- Lee, J., Lim, N., Yang, F. and Min Lee, S. 441
- Lees, J. and Manning, N. 509
- Leger, M.F. 216
- Leichenring, F., Abbass, A., Hilsenroth, M.J., Luyten, P., Munder, T., Rabung, S. et al. 530
- Leijssen, M. 160
- Leiter, M.P. and Maslach, C. 440, 441
- Leiter, M.P., Bakker, A.B. and Maslach, C. 503
- Lemma, A., Target, M. and Fonagy, P. 113
- Lener, R. 372
- length of sessions 497–8
- Lenz, A. S., Zamarripa, M. X. and Fuentes, S. 88
- Leonard, R. C., Knott, L. E., Lee, E. B., Singh, S., Smith, A. H., Kanter, J. et al. 148
- Leonidaki, V., Lemma, A. and Hobbis, I. 113, 114
- Lester, D. 513, 514
- L'Etang, S. and Theron, L. 483
- Levant, R.F. 386
- Levenson, H. 113
- Levenson, H. and Strupp, H.H. 113
- Levinas, Emmanuel 201, 302, 453
- Levinson, H. 332
- Levitt, B. 158
- Levitt, Heidi 74
- Levitt, H.M. and Piazza-Bonin, E. 422
- Levitt, H.M. and Williams, D.C. 74, 306
- Levitt, H.M., Butler, M. and Hill, T. 74, 288
- Levitt, H.M., Korman, Y. and Angus, L. 73
- Levitt, H.M., Neimeyer, R.A. and Williams, D.C. 74
- Levitt, H.M., Pomerville, A. and Surace, F.I. 74, 488
- Levy, R.A., Ablon, J.S. and Kächele, H. 486
- Lewin, Kurt 186–7, 511
- Lewis, J., Clark, D. and Morgan, D. 502
- LGBT community
- LGBTQ+ (lesbian, gay, bisexual, transgender, intersex, queer, questioning, BDSM/ Kink, nonbinary, asexual, consensual non-monogamous, and other diverse sexualities and practices)
  - gender and sexuality 387–8
  - religion, spirituality and 268
- liberal feminism 379
- Liddle, B.J. 52
- Lietaer, G. 157, 159
- life cycle, notion of 231
- life experience, ability to draw constructively on 414–15
- life scripts 177–9
- lifelong learning, preparation for 430
- lifestyle interventions 275
- Lilliengren, P. and Werbart, A. 7, 75, 114, 488
- Lindhiem, O., Bennett, C. B., Rosen, D. and Silk, J. 52, 516
- Linehan, M.M. 135, 137
- Lipkin, S. 485
- listening 20
- living dialogue 162
- Lizarazo, N. E., Muñoz-Martínez, A. M., Santos, M. M. and Kanter, J. W. 148
- Llewelyn, S. P., Elliott, R., Shapiro, D. A., Hardy, G. and Firth-Cozens, J. 487
- Llewelyn, S.P. 487
- Lock, A. and Strong, T. 210, 211
- Loewenthal, D. 243
- Loewenthal, D. and House, R. 133
- Loewenthal, D. and Proctor, B. 530
- Lømo, B., Haavind, H. and Tjersland, O.A. 60
- London, P. 285
- Long, P.S. and Lepper, G. 73
- long-term therapy 498
- social justice for long-term users 403
- Longo, Y., Coyne, I and Joseph, S. 165
- Looyeh, M. Y., Kamali, K., Ghasemi, A. and Tonawanik, P. 218

- Lopes, R. T., Gonçalves, M. M., Fassnacht, D. B., Machado, P. P. and Sousa, I. 218
- Lott, B. 6
- Lott, D.A. 367
- Love, M. and Farber, B.A. 80
- low-intensity support workers 507
- Luborsky, L. and Crits-Christoph, P. 114
- Luborsky, L., Barber, J. P. and Diguier, L. 114
- Luborsky, L., Crits-Christoph, P. and Mellon, J. 486
- Luborsky, L., Diguier, L., Seligman, D. A., Rosenthal, R., Krause, E. D., Johnson, S. et al. 477
- Luedke, A. J., Peluso, P. R., Diaz, P., Freund, R. and Baker, A. 86
- Lui, J. H., Marcus, D. K. and Barry, C. T. 516
- Lundahl, D., Tollefson, D., Gambles, C. and Brownell, C. 137
- Lutz, W., Leon, S. C., Martinovich, Z., Lyons, S. J. and Stiles, W. B. 489
- Lyman, E.L. 25
- Lynch, D., Laws, K. R. and McKenna, P. J. 133
- Lynch, K. 453
- Lyotard, Jean-François 222
- M**
- McBride, K. 517
- McCallum, M. and Piper, W. 54
- McCarthy, K. S., Keefe, J. R. and Barber, J. P. 81
- McCarthy, K.S. and Barber, J.P. 22
- McClafferty, C. 148
- McCormack, L. and Joseph, S. 165
- McCrone, P., Knapp, M., Proudfoot, J., Ryden, C., Cavanagh, K., Shapiro, D. A. et al. 516
- McCullough, L. 114
- Macdonald, W., Mead, N., Bower, P., Richards, D. and Lovell, K. 507, 521
- MacDougall, C. 161
- Mace, C. 53
- MacFarlane, P., Anderson, T. and McClintock, A. S. 157
- McGee, M. 517
- McGoldrick, M., Gerson, R. and Petry, S. 235
- McGuire, J., Nieri, D., Abbott, D., Sheridan, K. and Fisher, R. 456
- MacIntyre, A. 450
- Mackay, H.C., West, W., Moorey, J., Guthrie, E. and Margison, F. 111
- McKenna, P. and Todd, D. 11
- Mackrill, T. 57, 306
- McLean, S. and Kapell, B. 519
- McLean, S. M., Booth, A., Gee, M., Salway, S., Cobb, M., Bhanbhro, S. et al. 87
- McLellan, A.T., Woody, G.E., Luborsky, L. and Gohl, L. 489
- McLeod, J. and McLeod, J. 21, 64, 309, 334, 371, 428, 507
- McLeod, Julia 4, 31, 52, 74, 79, 151, 169, 182, 218, 248, 250, 302, 308, 310, 311, 312, 368, 403, 420, 467, 477, 478, 480, 481, 491, 492, 520
- McManus, F., Shafran, R. and Cooper, Z. 134
- McMillan, M. and McLeod, J. 6, 163
- Macmurray, John 201
- McNally, R.J. and Geraerts, E. 460
- McNamee, S. and Gergen, K.J. 211
- McNeill, B.W. and Worthen, V. 433
- McNeill, J.T. 320
- McNeilly, C.L. and Howard, K.I. 22
- McNulty, N., Ogden, J. and Warren, F. 465
- McQuaid, C. 428
- Macran, S. and Shapiro, D.A. 436
- Macran, S., Stiles, W. B. and Smith, J. A. 436
- Madigan, S. 211
- Madison, G. 160
- Magai, C. and Haviland-Jones, J. 122, 187
- Magnavita, J.J. 295
- Maguire, G. P., Goldberg, D. P., Hobson, R. F., Margison, F., Moss, S. and O'Dowd, T. 111
- Mahler, Margaret 105
- Mahoney, Michael J. 124, 137, 219–20, 221
- Mahoney-Davies, G., Roberts-Collins, C., Russell, A. and Loades, M. 125
- Mahrer, A.R. 155, 308
- Mahrer, A.R., Gagnon, R., Fairweather, D.R., Boulet, D.B. and Herring, C.B. 66
- Mahrer, A.R., Nadler, W.P., Dessaulles, A., Gervaise, P.A. and Sterner, I. 63, 487
- Main, J.A. and Scogin, F.R. 519
- Main, Mary 107, 108
- Mair, Miller 69, 219
- Maisel, R., Epston, D. and Borden, A. 214
- Maitland, D.W.M. and Gaynor, S.T. 148
- Maitland, D.W.M., Kanter, J.W., Tsai, M., Kuczynski, A.M., Manbeck, K.E. and Kohlenberg, R.J. 431
- Maitland, D.W.M., Petts, R., Knott, L., Briggs, C.A., Moore, J. and Gaynor, S.T. 148
- making art 246–7
- client experience of, research on 249

- making sense
  - art in making sense of therapy 249
  - from existential perspective 201
- Malan, David H. 98, 110, 111, 486
- Malchiodi, C.A. 241
- Maljanen, T., Knekt, P., Lindfors, O., Virtala, E., Tillman, P., Härkänen, T. et al. 480
- Mallinckrodt, B., Choi, G. and Daly, K. D. 43
- Maluccio, A. 487
- Mann, D. 110
- Mann, J. 465
- Manring, J., Greenberg, R. P., Gregory, R. and Gallinger, L. 428
- Mansell, W., Harvey, A., Watkins, E. and Shafran, R. 134
- Mansour, S., Bruce, K.R., Steiger, H., Zuroff, D.C., Horowitz, S., Anestin, A.S. et al. 510
- Manthei, R.J. 7
- Maori philosophy of life 348
- Maples, J.L. and Walker, R.L. 84
- Marlatt, G.A. and Kristeller, J.L. 130
- Marley, E. 4
- Marmarosh, C.L., Thompson, B., Hill, C., Hollman, S. and Megivern, M. 54
- Marmor, J. 418
- Maroda, K.J. 97
- Marshall, D., Quinn, C., Child, D., Shenton, D., Pooler, J., Forber, S. et al. 9, 86
- Marston, A.R. 415
- Mårtensson, L. and Andersson, C. 518
- Martin, C., Godfrey, M., Meekums, B. and Madill, A. 464
- Marzillier, John 25, 294, 430, 491
- Mascher, J. 216
- Maslach, C. and Jackson, S.E. 441
- Maslow, Abraham 151, 154, 326
- Mason, P.T. and Kreger, R. 517
- Masson, J. 380–81, 427, 454
- master therapists, interviews with 423
- matching client-therapist culturally 354–7
- Mavranouzouli, I., Mayo-Wilson, E., Dias, S., Kew, K., Clark, D. M., Ades, A. E. et al. 480
- May, R. 200
- May, R., Angel, E. and Ellenberger, H. 200
- Mayotte-Blum, J., Slavin-Mulford, J., Lehmann, M., Pesale, F., Becker-Matero, N. and Hilsenroth, M. 73, 490
- Mead, N., MacDonald, W., Bower, P., Lovell, K., Richards, D., Roberts, C. et al. 519
- meaning
  - existential therapy and 199
  - in life, gain of finding 14
  - meaning-making, emergence as core therapeutic task 221
- Meara, N.M., Schmidt, L.D. and Day, J.D. 451
- Meares, Russell 111
- Mearns, D. 77
- Mearns, D. and Cooper, M. 35, 163, 206, 438
- Mearns, D. and Thorne, B. 51, 153, 157, 161, 162, 165, 169, 309
- meditation
  - competence in therapists, professional structure for support of 437
  - embodied conversations 274
- Meekums, B. 491
- Meichenbaum, Donald 123, 124, 137, 138, 219, 220
- Melchert, T.P. 295
- Mellacqua, Z. 182
- Mellor-Clark, J. 479
- Mellor-Clark, J. and Barkham, M. 479
- Mellor-Clark, J., Barkham, M., Connell, J. and Evans, C. 479
- Melnick, J. and Nevis, E.C. 192
- memory, cognitive distortion and role of 123
- Menchola, M., Arkowitz, H.S. and Burke, B.L. 517, 519
- Menon, V., Rajan, T.M. and Sarkar, S. 515
- Mental Health Foundation 479
- Mental Research Institute (MRI) in Palo Alto 222, 232
- mentalisation, concept of 109
- Menzies, I. 503
- Mercer, J. 109
- Merleau-Ponty, Maurice 193, 201
- Merriman, O. and Joseph, S. 165
- Merry, T. and Brodley, B.T. 158
- Mesmer, Franz Anton 323
- Messer, S.B. 294
- meta-analysis 477
- meta-theoretical integration 293
- metacognition
  - cognitive-behavioural therapy (CBT) and 123
  - metacognitive therapy 138–9
- metacommunication
  - pluralistic therapy 309–10
  - therapeutic process 50
  - therapeutic relationship 38
- metaphor
  - use in cognitive-behavioural therapy (CBT) 131
  - use in therapeutic process 73
- method
  - concept in pluralistic therapy 308
  - methodological pluralism, importance of 474
- Michalak, J. and Holtforth, M.G. 57
- micro-skills 20–22
- microaggression
  - invisible dynamics of cultural difference and 358–9

- social concerns, therapy and 366
- Midgley, N., Holmes, J., Parkinson, S., Stapley, E., Eatough, V. and Target, M. 4
- Milan group and collective family reality 232
- Milchman, M.S. 460
- Mill, John Stuart 450
- Millar, A. 7
- Miller, Alice 518
- Miller, B. 423
- Miller, E. and Willig, C. 304
- Miller, Gavin 325
- Miller, J.B. 382
- Miller, Jean Baker 379
- Miller, J.K. and Slive, A.B. 501
- Miller, S. D., Duncan, B. L. and Hubble, M. A. 43
- Miller, Scott 78, 287–8
- Miller, S.D. and Berg, I.K. 221
- Miller, S.D., Prescott, D.S. and Maeschalck, C. 37, 79, 500
- Miller, William R. 63, 136
- Miller, W.R. and Rollnick, S. 136
- Miller, W.R. and Rose, G. 137
- Millett, Kate 380
- Milnes, P. 182
- mindfulness
- cognitive-behavioural therapy (CBT) 130–31
  - embodied conversations 274
  - mindfulness-based cognitive therapy (MBCT) 137
- Minuchin, Salvador 232
- ‘miracle question’ 223
- ‘mirror neurons’ 272
- Mitchell, R. 381
- modern world, dilemmas of 321
- modular integration 292
- Moertl, K., Giri, H., Angus, L. and Constantino, M.J. 436
- Moir-Bussy, A. 257
- Mojta, C., Falconier, M.K. and Huebner, A.J. 438
- Moleski, S.M. and Kiselica, M.S. 462
- Moltu, C., Binder, P.E. and Nielsen, G.H.S. 77
- Moltu, C., Veseth, M., Stefansen, J., Notnes, J.C., Skjølberg, Å., Binder, P.E. et al. 79, 492
- monitoring
- focus in CBT on 125
  - ongoing assessment of target behaviours 131
- Monk, G., Winslade, J., Crocket, K. and Epston, D. 211
- Montgomery, A. 272
- Moodley, R. 353
- Moon, L. 389
- Moore, Dr. Lawrence 456–7
- moral decision-making 450–51
- moral dimension of pluralistic therapy 301–2
- moral injury, gain in address of 15
- ‘moral panic’ within society, counselling and 331
- moral theory
- construction of morality 342
  - practical application of 451
- see also* ethical and moral framework
- Moran, D. 152, 196
- Moran, D. and Mooney, T. 152, 196
- Moreno, Jacob 246, 511
- Moreno, Zerka 246, 380
- Morgan, A. 212, 215
- Morley, R. 490
- Morris, B. 10
- Morrison, K.H., Bradley, R. and Westen, D. 476, 498
- Morrison, L.A. and Shapiro, D.A. 51
- Morrisette, P.J. 441
- Morrow-Bradley, C. and Elliott, R. 492
- Mortola, P. 192
- Mosher, C.M. 391
- Mosher, J.K. and Stiles, W.B. 10
- Mothersole, G. 180
- motivational
- interviewing 136–7
- Mountain, A. 179
- Mulley, A., Trimble, C. and Elwyn, G. 305
- multi-family therapy 232–3
- multiculturalism
- multicultural therapies, guidelines for 359–60
  - responses to trend towards 339
- multiple relationships 462–3
- Muncey, T. 491
- Munder, T., Bruetsch, O., Leonhart, R., Gerger, H. and Barth, J. 477
- Munder, T., Gerger, H., Trelle, S. and Barth, J. 477
- Munich, R.L. and Allen, J.G. 77
- Muran, Christopher 39, 45, 77
- Muran, J.C. and Barber, J.P. 486
- Murase, K. 348
- Murdock, N.L., Edwards, C. and Murdock, T.B. 85
- Murphy, D. and Cramer, D. 164
- Murphy, D. and Joseph, S. 165
- Murphy, D., Cramer, D. and Joseph, S. 164
- Murphy, L.J. and Mitchell, D.L. 515
- Murray, H.A. 489
- music in therapy 241, 245–6
- mutual alignment, maintenance of 31
- mutualism, philosophy of 331
- mutuality in person-centred therapies 163–4
- Myers, S.A. and White, C.M. 10
- Myers-Shirk, S.E. 325
- N**
- Nachmani, I. and Somer, E. 10, 464
- Naess, Arne 252–3
- Nahon, D. and Lander, N.R. 448
- Naikan* therapy in Japan 348
- narcissism, absence of 417–18
- narrative approaches to therapy 208–28
- collaborative therapy 225

- narrative approaches to  
therapy (*Continued*)  
constructivism 209–10  
constructivist therapy 219–21  
loss or bereavement,  
constructivist  
counselling for 221  
mirror time, use in 220  
for PTSD, use of metaphor  
in 220–21  
conversation 209, 227  
dialogical therapy 225–6  
case study, open dialogue  
in action 226  
open dialogue approach,  
success factors  
for 225–6  
dialogue 227  
discussion topics 228  
fixed role therapy 219  
language, use of 209, 222  
meaning-making,  
emergence as core  
therapeutic task 221  
narrative-informed  
approaches to  
therapy 218–27  
narrative templates, therapy  
concepts as 420  
narrative therapy 211–18  
‘absent but implicit’  
concept 215  
audiences, use of 215–16  
case study,  
externalisation in  
action 213–14  
case study, re-authoring  
therapy 212  
communities, working  
with 216–17  
community resources,  
enlistment of 214  
‘definitional  
ceremonies’ 215–16  
externalising the  
problem 212–14  
key ideas  
underpinning 211–12  
metaphoric  
storytelling 216  
reflecting teams 215–16  
research on 217–18  
significance of 218  
storytelling 216  
therapist style 214–15  
visual storytelling 216  
philosophical context 209–11  
post-structuralism 210  
postmodernism 210  
radical theatre  
tradition 226–7  
reading suggestions 228  
reflection topics 228  
research to inform practice,  
narrative case  
studies 490  
social constructionism 210  
social therapy model 227  
solution-focused  
therapy 221–5  
change, focusing on  
222–3  
Erickson’s contribution  
to 222  
exception finding 223  
homework tasks,  
exploring resources  
and 223–4  
‘miracle question’ 223  
pithy slogans, use of 223  
problem-focused therapy  
and, comparison  
with 224  
problem-free talk 223  
radical shift in 224–5  
scaling 223  
theatre of the  
oppressed 226–7  
*Narrative Means to  
Therapeutic Ends*  
(White, M.  
and Epston, D.) 211  
Nasar, J.L. and Devlin, A.S. 40  
National Institute for Health  
and Care Excellence  
(NICE) 516, 520  
national statutory  
agencies 503  
Native American sweat lodge  
ceremonies 348–9  
nature therapy 255  
Ncube, N. 216  
negative attitudes  
social attitudes to LGBT  
community, dealing  
with 388–9  
of therapists to gender and  
sexual diversity 390  
Neimeyer, G.J., Taylor, J.M.  
and Rozensky, R.H.  
525, 530  
Neimeyer, G.J., Taylor, J.M.,  
Rozensky, R.H. and  
Cox, D.R. 525, 530  
Neimeyer, R.A. 221  
Neimeyer, R.A., Herrero, O.  
and Botella, L. 221  
Neimeyer, R.A., Prigerson, H.G.  
and Davies, B. 221  
neoliberalism, effects of  
328–9  
Neugebauer, R. 320  
Neukrug, E., Bayne, H.,  
Dean-Nganga, L. and  
Pusateri, C. 157  
Neukrug, E., Milliken, T. and  
Walden, S. 454  
Neumann, D.A. and Gamble,  
S.J. 441  
neurobiological perspective  
interventions reflecting  
274–5  
risks of uncritical  
acceptance of 278–9  
neuroscience  
advances in 271–2  
significance of 272, 279  
New Public Management 503  
Newman, Fred 227  
Nichols, M. and Tafuri, S. 234  
Nickerson, A., Bryant, R.A.,  
Silove, D. and  
Steel, Z. 528  
Nielsen, S.R., Smart, D.W.,  
Isakson, R.L., Worthen,  
V.E., Gregersen, A.T.  
and Lambert, M.J. 482  
Nilsson, T., Svensson, M.,  
Sandell, R. and Clinton,  
D. 10, 75, 114  
Nissen-Lie, H.A., Monsen,  
J.T. and Rønnestad,  
M.H. 417



- Nissen-Lie, H.A., Rønnestad, M.H., Hoglend, P.A., Havik, O.E., Solbakken, O.A., Stiles, T.C. et al. 417
- Nolte, J. 246
- non-directiveness, troubled concept of 158
- non-judgementalism 446, 447–8
- non-maleficence 449
- non-professional counsellors 505–6
- non-specific therapeutic factors perspective 283
- non-verbal behaviour 344
- Norcross, J.C. 285, 517, 518
- Norcross, J.C. and Guy, J.D. 435–6
- Norcross, J.C. and VandenBos, G.R. 442
- Norcross, J.C., Pfund, R.A. and Prochaska, J.O. 525, 527
- Norcross, J.C., Strausser, D.J. and Missar, C.D. 436
- Norcross, J.C., Zimmerman, B.E., Greenberg, R.P. and Swift, J.K. 88, 491
- Normann, N., van Emmerik, A.A. and Morina, N. 138
- Nouwen, H.J.M. 416
- Novak, E.T. 177
- Novey, T.B. 182
- Nussbaum, Martha 398, 452
- Nuttall, J. 265
- Nwoye, A. 396
- Nye, A., Connell, J., Haake, R. and Barkham, M. 169
- O**
- object relations school 101–3
- observing art 247
- obsessional rituals, dealing with 132
- obsessive-compulsive disorder (OCD) 131, 132, 134
- living with 9
- O'Connell, B. 224
- O'Connor, T.S., Davis, A., Meakes, E., Pickering, R. and Schuman, M. 217
- O'Connor, T.S., Meakes, E., Pickering, R. and Schuman, M. 217
- Oddli, H.W. and Halvorsen, M.S. 36
- Oddli, H.W. and Rønnestad, M.H. 36, 57, 60
- Oddli, H.W., McLeod, J., Reichelt, S. and Rønnestad, M.H. 36
- Oddli, H.W., Nissen-Lie, H.A. and Halvorsen, M.S. 64
- Oei, T.P. and Shuttlewood, G.J. 475
- O'Hanlon, Bill 221
- O'Hanlon, W.H. and Weiner-Davis, M. 221
- O'Hara, D. 59, 288
- Ohlsson, T. 182
- OK-ness, idea of 173–4
- Okiishi, J., Lambert, M.J., Nielsen, S.L. and Ogles, B.M. 410, 489
- O'Leary, C. 510
- Olivera, J., Braun, M., Penedo, M.G. and Roussos, A. 9
- Olkin, R. 403
- O'Neill, I. 501
- O'Neill, P. 51, 306, 459
- ongoing self-examination 397
- ongoing support, therapy without end 89
- online assessment 515
- online information 4
- online systems, knowledge availability through 527–8
- online therapy sites 516
- ontological insecurity 206
- openness
- to learning and inquiry 412, 421–2
- to new experience 69–70
- OQ self-report scale 478, 479
- Orbach, Susie 381, 382
- organisation-level ethical initiatives 452
- organisational contexts 502–4
- organisational cultures 503–4
- organisational settings
- structure of organisations, transactional analysis and 181–2
- working in specific setting 401
- organismic valuing process 154
- Orlinsky, D.E. and Rønnestad, M.H. 155
- Orlinsky, D.E., Norcross, J.C., Rønnestad, M.H. and Wiseman, H. 436
- Orlinsky, D.E. Rønnestad, M.H., Willutzki, U., Wiseman, H. and Rotermans, J.-F. 436
- Oster, Gerald 242
- outcome-oriented case studies 481
- Outcome Rating Scale (ORS) 238, 287
- outcomes research 471, 474–84
- conclusions on 483
- outdoor environment, therapy in nature and use of 252–8
- adventure therapy 254–5
- case study, action on overcoming eating disorders 254–5
- animal-assisted therapy 256
- deep ecology 252–3
- discussion topics 258
- ecofeminism 253
- ecopsychology 253–4
- embodied conversations in outdoor time 275
- health benefits of outdoors 253
- horticulture therapy 255–6
- nature therapy 255
- outdoor therapy, forms of 253–7
- outdoors, health benefits of 253
- political dimensions of outdoor therapy 257
- reading suggestions 258
- reflection topics 258

outdoor environment, therapy  
     in nature and use of  
     (*Continued*)  
     research on outdoor  
     therapies 257  
     shifting therapy 'space' 257  
     social justice dimensions of  
     outdoor therapy 257  
     talk therapy out of  
     doors 256–7  
     wilderness therapy 254–5  
     'outsiderness,' condition of 415  
 Outward Bound tradition 254  
 over-confrontational  
     therapy 460  
 over-generalisation 122  
 Overholser, J.C. 128, 402  
 Overington, L. and  
     Ionita, G. 79  
 Owen, J., Drinane, J., Tao, K.  
     W., Adelson, J. L., Hook,  
     J. N., Davis, D. et al. 86  
 Owen, J., Reese, R. J., Quirk, K.  
     and Rodolfa, E. 36, 486  
 Owen, J., Wampold, B., Kopta,  
     M., Rousmaniere, T. and  
     Miller, S. 426–7

## P

Pachankis, J.E. and Goldfried,  
     M.R. 389  
 Pack, M. 429  
 Page, S. and Wosket, V. 433  
 painful experiences,  
     disclosure of 377–8  
 painting in therapy 241, 242–3  
 Paleg, K. and Jongma, A.E. 511  
 Palmer, S. and McMahon, G. 53  
 Papadopoulos, L., Bor, R. and  
     Stanion, P. 235  
 paraprofessional  
     counselling 506–7  
 parent-child relationship 197  
 Parlett, M. and Page, F. 188  
 Parlett, Malcolm 185  
 Parloff, M.B. 283  
 Parry, A. and Doan, R.E. 211  
 Parsons, Frank 331, 334  
 partial integrations 291  
 Pascual-Leone, A. and  
     Greenberg, L.S. 79, 168

Pascual-Leone, A., Bierman,  
     R., Arnold, R. and  
     Stasiak, E. 168  
 Pascual-Leone, Antonio 168  
 past-orientation 343  
 Patterson, C.H. 354  
 Paulson, B., Everall, R. D. and  
     Stuart, J. 75  
 Pavlov, Ivan 118, 120, 121  
 payoff in games 177  
 Pearce, P., Sewell, R., Cooper,  
     M., Osman, S., Fugard,  
     A.J. and Pybis, J. 169  
 Pearlman, L.A. and McIan,  
     P.S. 441  
 Pearson, A. and Weinberg, A.  
     414  
 Pearson, M. and Bulsara, C. 7  
 Pearson, M. and Wilson, H. 40  
 Peck, Scott 518  
 Pedersen, P.B. 339, 342  
 Peebles, M.J. 436  
 peers 509  
 Peiry, L. and Frank, J. 241  
 Pelmanism 330  
 Pelzer, Dave 518  
 penis envy hypothesis  
     380–81  
 Penn, L.S. 234  
 Pennebaker, James 243  
     Pennebaker paradigm 244  
 Peräkylä A., Antaki, C.,  
     Vehvilainen, S. and  
     Leudar, I. 50  
 Percy, I. 510  
 Perkins, R. 501  
 Perkins, R. and Scarlett, G. 501  
 Perls, Fritz 185, 186, 187, 188,  
     190  
 Perls, F.S., Hefferline, R.F. and  
     Goodman, P. 188  
 Perls, Laura 185, 186, 380  
 Perls' interests and values in  
     Gestalt therapy 186,  
     188  
 permeability of therapy  
     traditions 295  
 Perren, S., Godfrey, M. and  
     Rowland, N. 7, 64, 488  
 Perry, H.S. 143  
 persecutor in games 177

person, new types of 529  
 person-centred therapies  
     150–70  
     agency 162  
     congruence  
         presence and 157–8  
         value for therapy of 158  
     contact work 166  
     cultural specificity 161  
     difficult process, Warner's  
         perspective 164–5  
     disconnection, strategies  
         of 164  
     discussion topics 170  
     dissociated process 165  
     egosyntonic process 165  
     emotion-focused therapy  
         (EFT) 166–9  
     empathy 156–7  
     ethical and moral  
         framework 453  
         role of therapist in 459–60  
     evaluation, locus of 154  
     experiencing, centrality of  
         concept of 153–4  
     experiential focusing 159–61  
         case study of 160  
         use in therapy session,  
         case study of 160  
     expressive therapy 166  
     focusing on a problem,  
         process of 159–60  
     fragile process 164–5  
     fully functioning  
         person 154  
     humanistic counselling 169  
     humanistic therapies 165–9  
         philosophical and cultural  
         underpinning of 151–2  
     inner critic 162–3  
     living dialogue 162  
     mutuality 163–4  
     non-directiveness, troubled  
         concept of 158  
     organismic valuing  
         process 154  
     person-centred approach  
         evolution of 152–3  
         links between other  
         therapy traditions  
         and 169

- theoretical framework
  - of 153–61
- phenomenological approach
  - to knowledge 152
- post-traumatic growth 165
- pre-therapy, contact work
  - and 166
- presence 157–8
- reading suggestions 170
- reflection topics 170
- relational depth 163
- Rogers, enduring influence
  - of 155
- self-concept, idea of 154
- self-multiplicity 162–3
- theory and practice, further
  - developments in 161–5
- therapeutic process 158–9
- therapeutic
  - relationship 155–6
- willingness to be
  - known 157
- Wisconsin experiment
  - 152–3, 166
- working alliance model 163
- worth, conditions of 154
- personal development 429
- personal integration 293–4
- personal intuition 447
- personal power 397–8
- On Personal Power*
  - (Rogers, C.) 398
- personal problems, social
  - origins of 363–4
- personal qualities and
  - attributes of competent
    - therapists 409–10
- personal 'soundness' 411,
  - 414–18
- personal therapy 435–6
  - experiences of, diversity
    - of 437
  - impact on practice 436
- personal troubles, multiplicity
  - of ways of making
    - sense of 336
- personalisation 122
- personality, structure of 174
- Persons, J.B. 127
- Persons, J.B. and Davidson, J.
  - 127
- Persons, J.B. and Tompkins,
  - M.A. 127, 134
- Persons, J.B., Curtis, J.T. and
  - Silberschatz, G. 127
- persuasion, use of 459–61
- Persuasion and Healing*
  - (Frank, J.) 282–3
- Peters, H. 166
- petrification 206
- Pettersson, C. 518
- phased integration 292
- phenonemology
  - existential therapy,
    - phenomenological
      - approach in 201–2
    - knowledge,
      - phenomenological
        - approach to 152
- Philips, B. and Wennberg, P. 510
- Phillips, A. 106
- philosophical context
  - narrative approaches to
    - therapy 209–11
  - pluralistic therapy 300–302
- photography in therapy 241, 243
- PHQ self-report scale 478
- phrenology 322
- physical movement, embodied
  - conversations and 275
- physiological aspect of
  - writing 244
- Piaget, Jacques 102
- Pietkiewicz, I.J. and
  - Wlodarczyk, M. 461
- Piketty, T. 328, 375
- Pilgrim, D. and Guinan, P. 465
- Pinsof, William 437
- Pistrang, C. and Barker, C. 51
- Pittig, A., Kotter, R. and
  - Hoyer, J. 134
- place
  - considerations for delivery
    - formats 502–4
  - significance of 343
  - space and emotional
    - geography 367
- planned behaviour
  - change 65–6
- Plath, Sylvia 518
- Plotkin, B. 254
- Plumwood, V. 253
- pluralism, integrative
  - therapies and 296
- pluralistic therapy 299–316
  - alignment, maintenance
    - of 309–10
  - barriers to pluralism 315
  - case study, shared
    - understanding,
      - development of 304
  - change, facilitation of
    - 310–12, 315
  - collaborative case
    - formation 308–9
  - dialogue in
    - implication of 301
    - value of 312
  - discussion topics 315–16
  - ethical dimension of 301–2
  - exercise as cultural
    - resource 313
  - existing therapy
    - interventions, use
      - of 311
  - experimentation 311–12
  - feedback 310
  - goals, shared understanding
    - of 306
  - information, provision
    - of 306
  - informed consent 306
  - interpersonal skills 309
  - knowing, ways of 302
  - language, sensitivity to use
    - of 307
  - learning, facilitation of
    - 310–12
  - metacommunication 309–10
  - method, concept of 308
  - moral dimension of 301–2
  - philosophical context
    - 300–302
  - pluralism, concept of
    - 300–301
  - pluralistic service
    - delivery 313–14
  - practice of 302–12
  - pragmatic stance, adoption
    - of 303–4
  - preferences of clients,
    - significance of 308
  - reading suggestions 316

- pluralistic therapy (*Continued*)
  - reflection topics 315–16
  - relational ethics 302
  - relativism and, difference between 301
  - research 314
  - resources, concept of 312
  - scepticism, tradition of 301
  - shared decision-making 305–9
  - shared understanding, development of 303–4
  - supervision 314
  - task relevance 307–8
  - techniques and interventions from established schools, use of 311
  - theories as tools 303–4
  - theory, pragmatic perspective on use of 304
  - therapeutic tasks 307–8
  - training 314
- A Pluralistic Universe* (James, W.) 301
- Poddar, Prosenjit 456–7
- poetry writing 241
- political action, therapy as 395–406
- political context, influences of 328–9
- political dimensions of outdoor therapy 257
- political systems, adversarial polarities in 529–30
- Polkinghorne, D.E. 304, 530
- polyvagal theory 276–7
- Pomerantz, A.M. 459
- Pomerantz, A.M. and Handelsman, M.M. 459
- Pontes, L. and Pereira, R. 491
- Poole, M.S. and Hollingshead, A.B. 511
- Pope, Kenneth S. 334, 458, 462, 463
- Pope, K.S. and Keith-Spiegel, P. 462
- Pope, K.S., Keith-Spiegel, P. and Tabachnick, B.G. 464
- Pope, K.S., Levenson, H. and Schover, L.R. 464
- Porges, S. 276–7
- Porter, R. 320
- Portnoy, S., Girling, I. and Fredman, G. 216
- positioning 50
- positive client-therapist working relationship 36–7
- post-qualification training 430–31
- post-structuralism 210
- post-traumatic growth 165
- post traumatic stress disorder (PTSD) 220–21, 255, 387, 441, 513
- postmodernism 210
- Potter, K. and Coyle, A. 491
- Poulsen, S., Lunn, S. and Sandros, C. 7, 74, 114
- poverty
  - responding to 402
  - significance of 372–4
- power, concept of 397–8
- power sharing 397
- powerlessness 198
- practical reason 452
- practice-based outcome studies 478–9
- practice of
  - cognitive-behavioural therapy (CBT) 124–33
  - existential therapy 204–6
  - pluralistic therapy 302–12
  - transactional analysis 179–81
- practitioners, relevance of research for 492
- pragmatic case studies 490
- Pragmatic Case Studies in Psychotherapy* (online journal) 490
- pragmatic stance, adoption in pluralistic therapy of 303–4
- Praus, P., Riedel-Heller, S. and Dressing, H. 461
- pre-therapy
  - assessment, rationale for formality in 53
  - contact work and 166
- preferences
  - of clients, significance of 308
  - negotiation of 52
- preoccupied attachment pattern 108
- presence in person-centred therapies 157–8
- Present, J., Crits-Christoph, P. and Connolly Gibbons, M. B. 63
- present moment 343
- Presley, S. and Day, S.X. 86
- Pressly, P.K. and Heesaker, M. 40
- prevention
  - concept of 512–13
  - social concerns, therapy and 371
- Price, K. 370
- primary training 427–30
- Prince, R. 323
- principle-driven integration 294–5
- Prior, S. 100
- privilege, significance of 374
- problem-free talk 223
- problems
  - of living, diversity of beliefs and practices about dealing with 345–9
  - management of, concept of 289–90
  - problem-solving experience, gain of 14
  - problematic experience, stages in assimilation of 68
  - process of focusing on 159–60
- Probst, B. 436
- process as sequence 49
- process ethics 453–4
- process from client-centred perspective, studies of 484–5
- process from psychodynamic perspective, studies of 486
- process in therapy literature 47

- process research 471, 484–91
- professional identities,
  - emergence of other identities 333–5
- professional issues, training and 430
- professional knowledge
  - enhanced access to 527–8
  - research on 471, 491
- professional self-doubt 417–18
- professional services, demand for 526
- programmes, communities and 520
- progress, notion of 343
- projection
  - Gestalt therapy 189
  - projective identification, concept of 103–4
  - psychodynamic tradition 98
- Proudfoot, J., Ryden, C., Everitt, B., Shapiro, D.A., Goldberg, D., Mann, A. et al. 516
- Prouty, G. and Kubiak, H. 166
- Prouty, G., Van Werde, D. and Pörtner, M. 165, 166
- Prouty, Garry 166
- Pruitt, N.T. 25
- psychiatry as medical specialism,
  - establishment of 321–3
- Psychiatry* (journal) 143
- psychodynamic tradition
  - 93–115
  - accelerated experimental dynamic psychotherapy 114
  - Adult Attachment Interview (AAI) 108
  - affect phobia therapy 114
  - American post-Freudian tradition 105
  - analytic psychology 101
  - art in therapy,
    - psychoanalysis and use of 248–9
  - attachment theory 106–9
    - critical perspectives on 109
  - autonomous attachment pattern 108
  - brief psychodynamic therapy 110–14
  - British Independent group 104–5
  - building the tradition, key contributions 100–110
  - case studies
    - bowel problems, psychodynamic conversations about 112–13
    - psychodynamic therapy in practice 100
  - childhood origins
    - of emotional problems 95–6
  - children, techniques for dealing with 100
  - countertransference
    - 104–5
    - disciplined use of 99
  - defence, mechanisms of 98
  - defences, identification and analysis of 99
  - denial 98
  - discussion topics 115
  - dismissive attachment pattern 108
  - disorganised attachment pattern 108
  - displacement 98
  - dreams, working with 99
  - dynamic interpersonal theory (DIT) 113
  - early pioneers 101
  - ego 96–7
  - ego psychology 105
  - emotion, expression of 99
  - emotional problems,
    - childhood origins of 95–6
  - ethical and moral
    - framework, role of therapist in 459–60
  - European tradition 106
  - family therapy,
    - psychoanalytic thinking and 232
  - fantasies, working with 99
  - free association 99
  - Freud, work of Sigmund
    - 94–100
  - Gestalt therapy,
    - psychoanalytic origins of 186–7
  - id 96–7
  - Improving Access to Psychological Therapies (IAPT) programme 113
  - insecure-ambivalent attachment 107–8
  - insecure-avoidant attachment 107–8
  - insecure-disoriented attachment 107–8
  - insight, aim of 98
  - interpretation 99–100
  - mentalisation, concept of 109
  - object relations school
    - 101–3
  - preoccupied attachment pattern 108
  - projection 98
  - projective identification,
    - concept of 103–4
  - psychoanalysis,
    - historical context of contemporary practice 323–4
  - psychoanalysis in US, Freud and 326
  - psychodynamic-interpersonal
    - therapy 111–12
  - psychodynamic therapy,
    - origins of 94–100
  - reaction formation 98
  - reading suggestions 115
  - ‘real’ relationship 104
  - reflection topics 115
  - regression 98
  - repression 96, 97, 98, 103, 108
  - research on psychodynamic therapy 114
  - resistances, identification and analysis of 99
  - Rorschach Inkblot Test 100



- psychodynamic tradition  
     (*Continued*)  
     secure attachment 107–8  
     secure attachment  
         pattern 108  
     self-theory 105  
     sexual abuse, dealing  
         with 100  
     short-term dynamic  
         psychotherapy 114  
     splitting, idea of 102–3  
     sublimation 98  
     superego 96–7  
     Thematic Apperception Test  
         (TAT) 100  
     therapeutic structure,  
         maintenance  
         of security and  
         consistency in 99  
     therapeutic techniques  
         97–100  
     therapist-client relationship,  
         deliberate and  
         systematic use of 99  
     therapist self-awareness,  
         disciplined use of 99  
     ‘threes,’ thinking in terms  
         of, concept of ‘third’  
         and 110  
     time-limited dynamic  
         psychotherapy 113–14  
     transference, concept of 97  
     unconscious, importance of  
         the 96–7  
     unresolved attachment  
         pattern 108  
     Winnicott, influence of  
         D.W. 106  
 psychological distress, de-  
     objectification of 203  
 psychological  
     mindedness 53–4  
 Psychological Therapies  
     Research Centre 479  
 psychopharmacology 274–5,  
     279  
 psychosynthesis model 265  
 ‘psychotechnology’ 329, 530  
*Psychotherapedia* 295  
 psychotherapeutic help,  
     providers of 334–5
- psychotherapy  
     accelerated experimental  
         dynamic therapy 114  
     coming of age in US of  
         325–8  
     consuming psychotherapy 5  
     cultural construction of 336  
     emergence of 321–30  
     feminist critique of 380–81  
     recent history of 328–30  
 Psychotherapy and  
     Counselling  
         Association of Australia  
         (PACFA) 442  
 Pugach, M.R. and Goodman,  
     L.A. 7  
 Purton, C. 160  
 Putnam, Robert 365  
 Puvimanasinghe, T., Denson,  
     L.A., Augoustinos, M.  
     and Somasundaram,  
     D. 441  
 Pybis, J., Cooper, M., Hill, A.,  
     Cromarty, K., Levesley,  
     R., Murdoch, J. et  
     al. 169
- Q**  
 qualitative outcome  
     research 480–81  
 qualitative research, process  
     as experienced by  
     clients 487–8  
 qualities of effective  
     therapists 409–24  
     case formulation,  
         construction of 419  
     case study, Eri Viass,  
         exceptional  
         therapist 423  
     client experience, personal  
         qualities of therapist  
         and 418  
     conceptual ability 411,  
         418–20  
     decision to become a  
         therapist 416  
     discussion topics 424  
     Dreyfus model 410  
     emotional intelligence,  
         importance of 413–14
- ethical sensitivity 411, 412  
     exceptional therapists,  
         learning from 422–3  
     expertise, concept of 410  
     ‘family life, conflict in 415  
     interpersonal skills 411,  
         412–13  
     life experience, ability to  
         draw constructively  
         on 414–15  
     master therapists,  
         interviews with 423  
     narcissism, absence of  
         417–18  
     narrative templates, therapy  
         concepts as 420  
     openness to learning and  
         inquiry 412, 421–2  
     ‘outsiderness,’ condition  
         of 415  
     personal qualities and  
         attributes of competent  
         therapists 409–10  
     personal ‘soundness’ 411,  
         414–18  
     professional self-doubt  
         417–18  
     reading suggestions 424  
     reflection topics 424  
     research framework,  
         provision of 419–20  
     sense-making, offering to  
         clients ways of 419  
     social systems, ability to  
         work within 411, 421  
     structure in face of chaos,  
         need for 419  
     technique, mastery of 411,  
         420  
     therapist competence  
         dimensions of 411–22  
         making sense of 410–11  
     therapist wisdom, nature  
         of 421–2  
     therapy concepts as  
         cognitive tools 420  
     ‘wounded healer’ model  
         416–17  
 quantitative and qualitative  
     research 473–4  
 quasi-judicial case studies 490

- questioning technique in  
family therapy 234
- quilting in therapy 241
- Quintana, S.M. 84
- R**
- Rabin, A.I., Aronoff, J.,  
Barclay, A. and Zucker,  
R. 489
- Rabin, A.I., Zucker, R.,  
Emmons, R.A. and  
Frank, S. 489
- Råbu, M. and Haavind, H. 9,  
84, 87
- Råbu, M. and McLeod, J. 422,  
430
- Råbu, M., Binder, P.-E. and  
Haavind, H. 9, 87
- Råbu, M., Haavind, H. and  
Binder, P.-E. 7, 84, 87
- Råbu, M., Moltu, C., Binder, P.-E.  
and McLeod, J. 25
- 'race-avoidant'  
interventions 353
- Rachman, Stanley 473
- 'racket system' in  
transactional  
analysis 178–9
- Racusin, G.R., Abramowitz, S.I.  
and Winter, W.D. 415
- radical feminism 379
- radical shift in solution-  
focused therapy 224–5
- radical theatre tradition 226–7
- Radical Therapist* 172
- Rafaeli, E., Bernstein, D.P. and  
Young, J. 138
- Ramirez, M., III 351
- Randall, John 257, 517
- randomised clinical (or  
controlled) trials  
(RCTs) 473, 475–6, 478,  
479
- Rank, Otto 101, 326
- rapprochement, establishment of 125
- Rasmussen, B. 73
- Rasmussen, B. and Angus, L. 73
- Rath, J. 429
- rational emotive behaviour  
therapy, Ellis and 122
- Rauter, B.H. 182
- Ravitz, P. and Maunder, R. 146
- Rawson, D. 180
- Rayner, E. 105
- Rayner, M. and Vitali, D. 203
- Reaching Out About  
Depression (ROAD)  
programme 402
- reaction formation 98
- Read, J., Magliano, L. and  
Beavan, V. 363
- reading suggestions  
art in therapy, use of 251  
beginning therapy 61  
client's perspective 12  
cognitive-behavioural  
therapy (CBT) 141  
competence in therapists,  
professional structure  
for support of 444  
delivery formats for better  
access and effect 523  
embodied  
conversations 280  
ending therapy 90  
ethical and moral  
framework 469  
existential therapy 207  
families, working with 239  
future challenges 531  
gender and sexuality 394  
Gestalt therapy 194  
hard work of therapy 82  
historical context of  
contemporary  
practice 337  
interpersonal therapies 149  
narrative approaches to  
therapy 228  
outdoor environment,  
therapy in nature and  
use of 258  
person-centred therapies  
170  
pluralistic therapy 316  
psychodynamic  
tradition 115  
qualities of effective  
therapists 424  
religion and spirituality 269  
research to inform  
practice 493–4
- social concerns, therapy  
and 375
- social justice  
orientation 406  
therapist's perspective 26  
transactional analysis 184
- 'real' relationship 104  
concept of 34
- reality, concept of 341
- reality therapy 289
- recordings of sessions,  
benefits for clients  
listening to 71
- rededication school of  
transactional  
analysis 179–80
- Redhead, S., Johnstone, L. and  
Nightingale, J. 58
- reduction of symptoms, gain  
of 14
- Reese, R.J., Conoley, C.W. and  
Brossart, D.F. 514
- Reeve, D. 403
- referential self 342
- reflection  
on integrative therapies 291  
on outcome research 483  
reflecting teams in family  
therapy 235–6  
therapist's perspective 20–21  
on transactional  
analysis 182–3
- reflection topics  
art in therapy, use of 250  
beginning therapy 61  
client's perspective 11–12  
cognitive-behavioural  
therapy (CBT) 140  
competence in therapists,  
professional structure  
for support of 443–4  
culturally sensitive  
therapy 361  
delivery formats for better  
access and effect  
522–3  
embodied  
conversations 279–80  
ending therapy 89  
ethical and moral  
framework 469

- reflection (*Continued*)
    - existential therapy 207
    - families, working with 239
    - future challenges 531
    - gender and sexuality 393–4
    - Gestalt therapy 194
    - hard work of therapy 82
    - historical context of
      - contemporary practice 337
    - integrative therapies 298
    - interpersonal therapies 149
    - narrative approaches to therapy 228
    - outdoor environment, therapy in nature and use of 258
    - person-centred therapies 170
    - pluralistic therapy 315–16
    - psychodynamic tradition 115
    - qualities of effective therapists 424
    - religion and spirituality 269
    - research to inform practice 493–4
    - social concerns, therapy and 375
    - social justice orientation 405
    - therapeutic relationship 45
    - therapist's perspective 26
    - transactional analysis 183
  - reframing technique 234
  - Regan, A. and Hill, C.E. 80
  - regression 98
  - Rehm, I.C., Foenander, E., Wallace, K., Abbott, J.A.M., Kyrios, M. and Thomas, N. 516
  - Reich, Wilhelm 101, 186, 187, 271, 372, 396
  - Reis, B.F. and Brown, L.G. 52
  - relapse prevention 197
    - focus in CBT on 125
    - termination of CBT and planned follow-up 132–3
  - RELATE
    - delivery formats for better access and effect 502
  - historical context of
    - contemporary practice 331–2
  - relatedness in existential therapy 196–7
  - relational autonomy, principle of 448
  - relational consciousness 260
  - relational-cultural therapy 382–4
  - relational depth
    - person-centred therapies 163
    - therapeutic relationship 35
  - relational ethics
    - ethical and moral framework 446, 453–4
    - pluralistic therapy 302
  - relational styles 32
  - relational transactional analysis (TA) 180
  - relationship as container 28–9
  - relativism 301
  - religion and spirituality 259–69
    - affiliations, intensity and types of 266
    - case studies
      - religiously enhanced CBT 262
    - talking about religion in therapy groups 263
    - transpersonal themes, exploration in brief transactional analysis 265
  - dark side of 267–8
  - discussion topics 269
  - ethical issues 266
  - 'faith-adapted' therapy 263
  - globalisation of therapy and 260
  - harmful effects of organised religion 267–8
  - issues of, therapist attitudes and competence in working with 266
  - LGBT community and 268
  - psychosynthesis model 265
  - reading suggestions 269
  - rediscovery of 259–60
  - reflection topics 269
- relational
  - consciousness 260
  - relevance of 260–61
    - as resource 261–2
    - 'spiritual bypass' 267
  - spiritual techniques 263–5
  - spiritually informed therapy 261–2
  - therapeutic practice informed by 260–61
  - therapy and spirituality, barriers between 261–2, 267
  - therapy with members of specific faiths 263
  - transcendent reality 260
  - transpersonal psychotherapy 264–5
- Rennie, D.L. 7, 38, 80, 85, 310, 460, 487–8
- representation, modalities of 248
- repression 96, 97, 98, 103, 108
- research
  - art in communication of findings of 249–50
  - competence in therapists, professional structure for support of 442–3
  - framework for, provision of 419–20
  - new developments in transactional analysis 182
  - on outdoor therapies 257
  - pluralistic therapy 314
  - on professional ethics 454
  - on psychodynamic therapy 114
  - research-informed practice 430
  - on therapy, ethical issues in 467
- research to inform practice 470–94
  - action research 483
  - behaviour change, research on 480
  - behavioural case studies 489–90
  - case studies 489–91

research on, resurgence  
of interest in 490–91  
client satisfaction  
studies 474–5  
clients, relevance of  
research for 492  
collaborative relationships,  
capacity for 473  
Consumer Reports  
study 481, 482  
core conflictual relationship  
theme (CCRT) 486  
CORE self-report scale 478,  
479  
cost-effectiveness  
research 480  
discussion topics 493–4  
drop-out rates, research  
on 479–80  
effectiveness of  
therapists? 489  
effectiveness studies 474  
efficacy studies 474  
ethical issues in therapy  
research 491  
'events paradigm' 486–7  
first-person research 491  
GAD self-report scale 478  
harmful therapy, issue of 484  
historical development of  
research 472–4  
intellectual curiosity 472–3  
meta-analysis 477  
methodological pluralism,  
importance of 474  
narrative case studies 490  
OQ self-report scale 478, 479  
outcome-oriented case  
studies 481  
outcomes research 471,  
474–84  
conclusions on 483  
PHQ self-report scale 478  
practice-based outcome  
studies 478–9  
practitioners, relevance of  
research for 492  
pragmatic case studies 490  
principles for practice,  
process research and  
generation of 488

process from client-centred  
perspective, studies  
of 484–5  
process from  
psychodynamic  
perspective, studies  
of 486  
process research 471, 484–91  
professional knowledge,  
research on 471, 491  
qualitative outcome  
research 480–81  
qualitative research,  
process as experienced  
by clients 487–8  
quantitative and qualitative  
research 473–4  
quasi-judicial case  
studies 490  
randomised clinical  
(or controlled) trials  
(RCTs) 473, 475–6, 478,  
479  
reading suggestions 493–4  
reasons for doing  
research 471–2  
reflection topics 493–4  
reflections on outcome  
research 483  
structural change, research  
on 482  
surveys 481–2  
symptom measures,  
development of 476–7  
systematic case studies 489,  
490  
theory building case  
studies 490  
therapeutic allegiance  
of therapist, factor  
in outcome research  
of 477  
therapist effects, research  
on 471  
therapy research, range  
of 471  
TOPS self-report scale 478  
working alliances, studies  
of 485–6  
resilience 81, 127, 351, 363, 416,  
451, 512

resoluteness 70–71  
resolution  
of impasses 76–8  
resolution outcomes 14  
resources  
concept of 312  
resource factors, time-  
limited therapy and 500  
respect 28, 38, 153, 163, 436, 451  
response in games 177  
responsive relationship 31–2  
restating meaning 20–21  
restitution, gain of 15  
retroflexion 189  
Reynolds, D.K. 348  
Rheker, J., Beisel, S., Kräling,  
S. and Rief, W. 75, 484  
Rhodes, R.H., Hill, C.E.,  
Thompson, B.J. and  
Elliott, R. 7  
Rice, Laura 167  
Rice, L.N. and Greenberg,  
L.S. 151, 486–7  
Rice, L.N. and Wagstaff,  
A.K. 273  
Richards, D. and  
Timulak, L. 487  
Richards, D.A., Bower, P.,  
Pagel, C., Weaver, A.,  
Utley, M., Cape, J.  
et al. 521  
Richards, M. and Bedi, R.P. 7  
Richardson, J.D. and Stewart,  
D.N. 320  
Richardson, L. and Reid, C. 483  
Ricks, L., Kitchens, K.,  
Goodrich, T. and  
Hancock, E. 216  
Rieck, T. and Callahan,  
J.L. 413–14  
Rieger, K.L., Hack, T.F., Beaver,  
K. and Schofield, P. 71  
Rippere, V. and Williams,  
R. 416  
ritual healing, Ndembu doctor  
and 347  
Rizq, R. 504  
Rø, K.I., Veggeland, F. and  
Aasland, O.G. 509  
Robbins, T.T., Judge, T.A. and  
Campbell, S.P. 503

- Rober, P., Elliott, R., Buysse, A., Loots, G. and De Corte, K. 25, 80
- Rober, Peter 80, 232, 233
- Robinson, A. 168
- Robinson, A. and Elliott, R. 168, 169
- Rodda, S.N., Lubman, D.I., Cheetham, A., Dowling, N.A. and Jackson, A.C. 501
- Rodgers, B. and Elliott, R. 481
- Rodgers, N.M. 464
- Rodman, F.R. 106
- Rodolfa, E., Greenberg, S., Hunsley, J., Smith-Zoeller, M., Cox, D., Sammons, M. et al. 411
- Roe, D., Dekel, R., Harel, G., Fennig, S. and Fennig, S. 9, 84, 114
- Rogers, A. and Pilgrim, D. 403
- Rogers, Carl R. 29, 41, 47, 63, 282, 326, 330, 332, 397–8, 427
- congruence, definition of 157–8
- effective therapists, qualities of 412, 419–20
- enduring influence of 155
- Gestalt therapy 186, 187
- humanistic practices 166, 167, 169
- motivational interviewing 136
- persin-centred practice 151, 152–3, 154, 158, 161, 162, 163, 164
- pivotal role of 327
- psychotherapy, lead on professional recognition of 504
- research to inform practice, use of 472, 484–5, 487
- therapeutic growth, direction of 158–9
- therapeutic relationship, view on 155–6
- transactional analysis 172
- Rogers, C.R. and Dymond, R.F. 152, 487
- Rogers, C.R. and Stevens, B. 153
- Rogers, C.R., Gendlin, E.T., Kiesler, D.J. and Truax, C.B. 152, 166, 485
- Rogers, N., Tudor, K., Embleton Tudor, L. and Keemar, K. 166
- Rogers, Natalie 166, 249
- Rokeach, Milton 447
- Rokke, P.D., Carter, A.S., Rehm, L.P. and Veltum, L.G. 51
- Rollnick, S. and Allison, J. 136–7
- Romano, J.L. and Hage, S. 513
- Romme, M. and Escher, S. 508
- Ronan, K.R. and Kazantzis, N. 66
- Rønnestad, M.H. and Ladany, N. 426
- Rønnestad, M.H. and Skovholt, T.M. 410, 411, 416, 421, 422, 428
- Roos, J. and Wearden, A. 125
- Roos, J. and Werbart, A. 86
- Rorschach Inkblot Test 100
- Rose, E.M., Westefeld, J.S. and Ansley, T.N. 261
- Rose, S., Bisson, J. and Wessely, S. 513
- Rosenbaum, R. 501
- Rosenfield, M. 513, 514
- Rosenzweig, Saul 282
- Rosner, R.I. 143, 328
- Rosnow, R.L. and Rosenthal, R. 477
- Ross, A. 266
- Roth, A.D. 411
- Roth, A.D. and Pilling, S. 125
- Rothman, D. 320
- Rothschild, B. 276, 442, 460
- Roubal, J. 192
- Roubal, J. and Rihacek, T. 192
- Roubal, J., Francesetti, G. and Gecele, M. 189
- Rousmaniere, T. 439, 440
- Rousmaniere, T., Abbass, A. and Frederickson, J. 431
- Rousmaniere, T., Abbass, A., Frederickson, J., Henning, I. and Taubner, S. 431
- Rousmaniere, T., Goodyear, R.K., Milller, S.D. and Wampold, B.E. 439
- Rousmaniere, T., Swift, J.K., Babins-Wagner, R., Whipple, J.L. and Berzins, S. 434
- Rowan, J. and Cooper, M. 176
- Rowan, T. and O'Hanlon, B. 221
- Rowe, D. 517
- Rozental, A., Kottorp, A., Boettcher, J., Andersson, G. and Carlbring, P. 75
- Rubin, D.C. and Boals, A. 460
- Rudland Wood, N. 216
- ruptures in alliances, repair of 38–9
- Rushforth, Winifred 265
- Rustin, J. 109
- Rutter, P. 465
- Ryan, Judith 245
- Ryle, A. and Kerr, I.B. 58
- Ryle, Anthony 58, 290, 291
- ## S
- Sachse, R. and Elliott, R. 72
- Sachse, Rainer 72
- safety and staying safe 19–20
- Safran, Jeremy 39, 45, 77, 310
- Sagan, O. 365
- Sage Publishing 15
- Sales, C.M.D. and Alves, P.C.G. 79
- Salisbury, W.A. and Kinnier, R.T. 462, 463
- Salkovskis, P. 131
- Salkovskis, P., Rimes, K., Stephenson, D., Sacks, G. and Scott, J. 519
- Salmenniemi, S. and Vorona, M. 518
- Sælør, K.T., Ness, O., Borg, M. and Biong, S. 60
- Salzer, M.S., Rappaport, J. and Segre, L. 508
- Sampson, E.E. 342
- Samstag, L.W. 155



- San Francisco Psychiatric Institute 172
- Sanchez, A. and Shallcross, R. 218
- sand tray play 241
- Sandage, S., Moon, S., Paine, R., Ruffing, D., Kehoe, L., Bronstein, M. et al. 504
- Sandberg, J., Gustafsson, S. and Holmqvist, R. 42
- Sandell, R. 192
- Sandell, R. and Wilczek, A. 481
- Sandell, R., Blomberg, J., Lazar, A. 436
- Sanders, P. 153, 166
- Sanders, P. and Hill, A. 169
- Sands, Anna 5
- Sartre, Jean-Paul 196, 201
- Savickas, M.L. 334
- Saxon, D., Barkham, M., Foster, A. and Parry, G. 84, 86, 169
- Saxon, D., Ricketts, T. and Heywood, J. 86
- Sayre, G. 453
- scaling in solution-focused therapy 223
- scepticism, tradition of 301
- Schank, J.A. and Skovholt, T.M. 462
- Scheel, M.J., Hanson, W.E. and Razzhavaikina, T.I. 66, 130
- Scheel, M.J., Seaman, S., Roach, K., Mullin, T. and Mahoney, K.B. 66
- Scheff, T.J. 240
- Scheinberg, S., Johansson, A., Stevens, C. and Conway-Hicks, S. 192
- schema therapy 138
- Schiff, J.L., Schiff, A.W., Mellor, K., Schiff, E., Schiff, S., Richman, D. et al. 180
- schizophrenia (long-term), existential therapy for 205
- Schjelderup, H. 475
- Schmid, P.F. 163–4
- Schneibel, R., Wilbertz, G., Scholz, C., Becker, M., Brakemeier, E.L., Bschor, T. et al. 484
- Schneider, A.J., Mataix-Cols, D., Marks, I.M. and Bachofen, M. 516
- Schneider, K.J. and Längle, A. 151
- Schneider, K.J. and May, R. 200
- Schneider, K.J., Pierson, J.F. and Bugental, J.F.T. 151
- The Schopenhauer Cure* (Yalom, I.D.) 511
- Schore, A.N. 109
- Schore, J.R. and Schore, A.N. 109
- Schröder, D. 71
- Schuck, C. and Wood, J. 432
- Schultz, Christian 205
- Scott, A. 266
- Scull, A. 320, 321, 322
- sculpture in therapy 241, 242–3
- Searles, H. 465
- second-order structures 175–6
- Second World War, effects of 326–7
- secondary traumatisation 441
- secure attachment 107–8  
pattern for 108
- Segal, H. 101
- Segal, J. 101
- Segal, Zindel 137
- Segal, Z.V., Williams, J.M.G. and Teasdale, J.D. 137
- Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keranen, J. and Lehtinen, K. 225, 226
- Seikkula, J. and Arnkil, T.E. 225, 497
- Seikkula, J., Karvonen, A., Kykyri, V. L., Kaartinen, J. and Penttonen, M. 277
- Seiser, L. and Wastell, C. 23
- Self, R., Oates, P., Pinnock-Hamilton, T. and Leach, C. 372
- self-acceptance, gain of 14
- self-actualisation, gain of 14
- self-awareness  
gain of 14
- training and 399
- self-concept, idea of 154
- self-critical cognitions 121–2
- self-disclosure 21
- self-help  
groups 508–9  
learning materials 131  
materials 517–20  
mental health books 517–18  
reading, reviews of  
effectiveness of 519  
sources, diversity of 519–20
- self-multiplicity 162–3
- self-practice 438, 440
- self-sense 341–2
- self-theory 105
- Seligman, M.E.P. 182, 481, 482
- Selvini Palazzoli, Mara 232
- Sen, Amartya 398, 452
- sense-making, offering to  
clients ways of 419
- senses, imagination and  
thought 452
- sensitivity to questions in  
existential therapy 196
- Serlin, I.A. 186
- session extension, beginning  
therapy and 59
- Session Rating Scale  
(SRS) 238, 287
- sexual abuse, dealing with 100
- Sexual and Marital Therapy*  
(journal) 391
- sexual concerns, therapy  
for 390–92  
talking about sexual  
concerns, difficulties  
in 391–2
- sexual difficulties, existential  
therapy for 205
- sexual diversity, gender  
and 387–90
- sexual exploitation of  
clients 464–6
- Shafir, T. 275
- Shamdasani, S. 323
- Shapiro, D.A. 51
- Shapiro, D.A., Barkham, M., Rees, A., Hardy, G.E., Reynolds, S. and Startup, M. 112

- Shapiro, J., Nixon, L.L., Wear, S.E. and Doukas, D.J. 430
- shared decision-making 305–9
- shared language 37
- shared understanding, development of 303–4
- Sharpe, E.F. 73
- Sheach Leith, V.M. 491
- Shedler, J. 114, 486
- Shepherd, L., Salkovskis, P.M. and Morris, M. 71
- Shepherd, M. and Rosairo, M. 507
- shifting therapy 'space' 257
- Shinebourne, P. and Smith, J.A. 73
- Shingleton, R.M., Richards, L.K. and Thompson-Brenner, H. 515
- shinkeishitsu*, culture-bound syndrome of 346
- Shlien, J. 37
- short-term dynamic psychotherapy 114
- Shotter, John 210
- Showalter, E. 380
- Siegel, D.J. 272
- Siekkula, Jaakko 225
- Sifneos, P.E. 110
- Silberschatz, G. 155
- Silberschatz, G., Fretter, P.B. and Curtis, J.T. 486
- silence  
  silencing of voices 403  
  therapist's perspective 21
- Sills, Charlotte 58, 180, 182–3
- Silove, D. and Manicavasagar, V. 131
- Silverstone, Liesl 249
- Simmons, J. and Griffiths, R. 126
- Simpson, S. 515
- sincerity 451
- Singer, M.T. and Lalich, J. 454, 460
- single-session therapy 501–2
- Sinha, A., Bhola, P., Raguram, A. and Chandra, P. S. 468
- skills training 427–8
- Skinner, B.F. 118–19, 120, 146, 151
- Skovholt, T.M. and Jennings, L. 423
- Skovholt, T.M. and Trotter-Mathison, M. 442
- Slade, A. 370
- sleep interventions 275
- Slife, B.D. and Gantt, E. 474
- Slife, B.D., Scott, L. and McDonald, A. 448
- Slife, B.D., Wiggins, B.J. and Graham, J.T. 474
- Slive, A. and Bobele, M. 502
- Sloan, D.M. and Marx, B.P. 244
- Sloane, R.B., Staples, F.R., Cristol, A.H., Yorkson, N.J. and Whipple, K. 476
- Smit, Y., Huibers, M.J., Ioannidis, J.P., van Dyck, R., van Tilburg, W. and Arntz, A. 482
- Smith, D.P. and Orlinsky, D.E. 266
- Smith, J.A., Flowers, P. and Larkin, M. 202
- Smith, L., Mao, S., Perkins, S. and Ampuero, M. 165
- Smith, L., Rosenzweig, L. and Schmidt, M. 483
- Smith, Laura 372, 500
- Smith, M., Davidson, J., Cameron, L. and Bondi, L. 502
- Smith, M., Glass, G. and Miller, T. 477
- Snape, C., Perren, S., Jones, L. and Rowland, N. 87
- Snyder, J. and Silberschatz, G. 43
- social action  
  gain in generativity and 15  
  research 404  
  therapy 399
- social adversity, categories of 364
- social aspect of writing 244
- social behaviour, structural analysis of 33
- social capital 365
- social change  
  leaving clients with tools for 397  
  reshaping therapy in response to 329–30
- social class and status, significance of 372–4
- social concerns, therapy and 362–75
- adversity theory 364
- affluence, significance of 374
- befriending 369–70
- case study, neglect and abuse in foster care 369
- community-based  
  voluntary bereavement counselling 373
- depression, social origins of 363–4
- discussion topics 375
- distancing 367
- domestic violence, support groups and social capital formation among survivors of 365
- economic disadvantage, guidelines for dealing with people in 373–4
- employment loss, effects of 373
- Fromm, enduring legacy of Erich 367–8
- generic social repair processes 368
- humiliation, undoing effect of 368–9
- inequality 366
- microaggression 366
- narrative therapy 368
- personal problems, social origins of 363–4
- place, space and emotional geography 367
- poverty, significance of 372–4
- prevention 371
- privilege, significance of 374

- reading suggestions 375
- reflection topics 375
- social adversity, categories of 364
- social capital 365
- social class and status, significance of 372–4
- social degradation, undoing effect of 368–9
- social disadvantage, making sense of 364–7
- social interventions 368–71
- social involvement initiatives 370
- social matrix dreaming 370
- social outcomes of therapy, evaluation of 374
- social solidarity construction 368
- social support, therapeutic need for 371
- stress, conservation of resources model of 366
- stress, life events and 363
- weathering 366–7
- social construction of psychotherapy 336
- social constructionism 210
- social ecology of families, initiation of change in 236–7
- of professional therapy 443
- social involvement outcomes 14
- social justice orientation 395–406
  - advocacy 400–401
  - aim of social justice in therapy 396–7
  - American Counseling Association 396
  - biomedical model of disability 403
  - collaboration with practitioners from other occupational groups 401
  - consciousness-raising, facilitation of 397
  - Counseling Psychology Division of the American Psychological Association 396
  - critical consciousness, notion of 396
  - disabilities, counselling people with 402–3
  - discussion topics 405
  - ecologically informed therapy 403–4
  - ethical and moral framework 453
  - exclusion from expression 403
  - extreme situations, learning from 404
  - functional model of disability 403
  - human trafficking, responding to victims of 402
  - Just Therapy Team in New Zealand 398–9
  - justice, concept of 398
  - long-term users of psychiatric services, social justice for 403
  - ongoing self-examination 397
  - organisational setting, working in specific setting 401
  - outdoor therapy, social justice dimensions of 257
  - personal power 397–8
  - poverty, responding to 402
  - power, concept of 397–8
  - power sharing 397
  - Reaching Out About Depression (ROAD) programme 402
  - reading suggestions 406
  - reflection topics 405
  - self-awareness, training and 399
  - silencing of voices 403
  - social action research 404
  - social action therapy 399
  - social and political aspects of lives, talking about 400
  - social change, leaving clients with tools for 397
  - social ecology of clients, conceptualization of 401
  - social justice-oriented therapy 397–9
  - social justice therapy in action 400–404
  - social justice therapy practice, models of 398–9
  - social perspective on disability 403
  - socio-political context of therapy 404
  - structural inequality, responding to 402
  - ‘surveillance society,’ therapy in 400
  - sustainability, social justice and 396
  - training and self-awareness 399
  - working in specific organisational setting 401
- social origins of counselling and psychotherapy 320–21
- social skills gain in acquisition of 15
- social skills training 129
- social systems ability to work within 411, 421
- structures in US, social mobility and erosion of 325–6
- social therapy model 227
- socialist feminism 379
- society counselling and psychotherapy within 335–6
- ethical responsibilities to as a whole 458

- society (*Continued*)  
 therapy and, challenges  
   in relationship  
     between 528–30  
 socio-political context of  
   therapy 404  
 Socrates 30, 128  
 Socratic dialogue 128  
 Sollod, R.N. 324  
 solution-focused therapy  
   221–5  
   change, focusing on 222–3  
   Erickson's contribution  
     to 222  
   exception finding 223  
   homework tasks, exploring  
     resources and 223–4  
   'miracle question' 223  
   pithy slogans, use of 223  
   problem-focused therapy  
     and, comparison  
       with 224  
   problem-free talk 223  
   radical shift in 224–5  
   scaling 223  
 Solway, R., Camic, P.M.,  
   Thomson, L.J. and  
   Chatterjee, H.J. 39  
 Somer, E. and Nachmani, I.  
   464  
 Sommer, R. 518  
 Sommerbeck, L. 158  
 Sommers-Flanagan, J.,  
   Richardson, B.G. and  
   Sommers-Flanagan,  
   R. 460  
 Sori, C.F. and Hecker, L.L. 23  
 Southgate, Rosemary 517  
 Spangler, P.T., Hill, C.E., Dunn,  
   M.G., Hummel, A.M.,  
   Walden, T.T., Liu, J.  
   et al. 73  
 Spanos, I. 322  
 Speciale, M., Gess, J. and  
   Speedlin, S. 491  
 specific therapist  
   practices 20–24  
*The Spell of the Sensuous*  
   (Abram, D.) 252–3  
 Spence, D.P. 460, 489  
 Spinelli, Ernesto 200, 201  
 'spiritual bypass' 267  
 spiritually informed  
   therapy 261–2  
   spiritual techniques 263–5  
 Splevins, K.A., Cohen, K.,  
   Joseph, S., Murray, C.  
   and Bowley, J. 165  
 splitting, idea of 102–3  
 Spurling, L. and Dryden,  
   W. 415, 416  
 Stadler, H.A. 451  
 Standing Council for the  
   Advancement of  
   Counselling (UK) 331,  
   333  
 Stănicke, E. 482  
 Stănicke, E. and Killingmo,  
   B. 482  
 Stanley, I.H., Chu, C., Brown,  
   T.A., Sawyer, K.A. and  
   Joiner, T.E., Jr. 44  
 starting therapy  
   practical issues in 51–9  
   preparation for therapy 52  
   session extension,  
     beginning therapy  
     and 59  
 status of counselling and  
   psychotherapy  
   as autonomous  
   professions 526, 527  
 staying on track 76–9  
 Stearns, C. and Stearns, P. 118  
 Stefanopoulou, E., Lewis, D.,  
   Taylor, M., Broscombe,  
   J., Ahmad, J. and  
   Larkin, J. 515  
 Stein, D.M. and Lambert,  
   M.J. 505  
 Steiner, C. and Wyckoff, H. 172  
 Steiner, Claude 172, 177, 183  
 Štěpánková, R. 166  
 Stephenson, R.L. 67  
 stepped care 520–22  
 Stern, Daniel 78  
 Stevens, C. and Wakelin,  
   K. 192  
 Stewart, I. 179  
 Stewart, I. and Joines, V. 173  
 Stewart, R.E., Chambless, D.L.  
   and Baron, J. 492  
 Stewart, R.E., Stirman,  
   S.W. and Chambless,  
   D.L. 492  
 Stewart, S. and Schröder, T. 71  
 Stiegler, J.R., Binder, P.E.,  
   Hjeltne, A., Stige, S.H.  
   and Schanche, E. 168  
 Stiegler, J.R., Molde, H. and  
   Schanche, E. 168  
 Stiggelbout, A.M., Pieterse,  
   A.H. and De Haes,  
   J.C.J.M. 305  
 Stiggelbout, A.M., Van der  
   Weijden, T., De Wit,  
   M.P., Frosch, D., Légaré  
   F., Montori, V.M.  
   et al. 305  
 Stiles, Bill 17, 68, 163, 490  
 Stiles, W.B. and Glick, M.J.  
   163  
 Stiles, W.B. and Shapiro,  
   D.A. 81  
 Stiles, W.B., Barkham, M.,  
   Mellor-Clark, J. and  
   Connell, J. 478  
 Stiles, W.B., Barkham, M.,  
   Twigg, E., Mellor-Clark,  
   J. and Cooper, M. 133,  
   478  
 Stiles, W.B., Elliott, R.,  
   Llewelyn, S.P.,  
   Firth-Cozens, J.A.,  
   Marginson, F.R.,  
   Shapiro, D.A. et al. 68  
 Stiles, W.B., Honos-Webb, L.  
   and Surko, M. 17, 31  
 Stiles, W.B., Leach, C.,  
   Barkham, M., Lucock,  
   M., Iveson, S., Shapiro,  
   D.A. et al. 63  
 Stiles, W.B., Meshot, C.M.,  
   Anderson, T.M. and  
   Sloan, W.W. 20  
 Stinckens, N., Lietaer, G. and  
   Leijssen, M. 162  
 Stiver, I.P. 383–4  
 Stolorow, R.D. 412  
 Stone Center 382–3  
 storytelling  
   art in therapy, use of 241  
   stories, use of 131

- Stott, R., Mansell, W., Salkovskis, P., Lavender, A. and Cartwright-Hatton, S. 131
- Strasser, F. and Strasser, A. 200
- Strassle, C.G., Borckardt, J.J., Handler, L. and Nash, M. 52
- stress
- conservation of resources model of 366
  - life events and 363
- Stricker, George 294, 508
- Stroebe, W., Schut, H. and Stroebe, M. 513
- strokes, motivational concept of 173–4
- Strømme, H., Gullestad, S.E., Stånicke, E. and Killingmo, B. 482
- Strong, T. 225
- Strong, T. and Pyle, N.R. 50
- Strozier, M., Brown, R., Fennell, M., Hardee, J., Vogel, R. and Bizzell, E. 458
- structural analysis
- of social behaviour 33
  - transactional analysis 174–6
- structural change, research on 482
- structural inequality, responding to 402
- Strümpfel, U. 192
- Strupp, Hans H. 113–14, 115, 283, 472, 490, 507, 513
- Strupp, H.H. and Hadley, S.W. 490, 506–7
- Stuhr, U. and Wachholz, S. 34–5
- Sturmey, P. 119
- Stuthridge, J. and Sills, C. 177
- Subjective Units of Distress Scale (SUDS) 131
- sublimation 97, 98
- substance abuse,
- feminist-informed integrationism and working with 382
- Sue, D.W. and Sue, D. 350
- suggestion, use of 459–61
- suicide, responding to 431
- Sullivan, Harry Stack 143
- Sundet, R. 79, 310
- superego 96–7
- supervision
- competence in therapists, professional structure for support of 431–5
  - ‘cyclical’ model of supervision 433
  - formats for 432
  - modes of 432
  - pluralistic therapy 314
  - supervised practice 430
  - supervision process model 432–3
  - themes in 433–4
- supportive relationships 18–19
- ‘surveillance society,’ therapy in 400
- surveys 481–2
- Susskind, R. and Susskind, D. 526–8
- Sussman, M. 415, 424
- sustainability, social justice and 396
- Swan, K.L. and Schottelkorb, A.S. 166
- Swift, J.K. and Callahan, J.L. 52, 87
- Swift, J.K. and Greenberg, R.P. 86
- Swift, J.K. and Parkin, S.R. 488
- Swift, J.K., Callahan, J.L., Ivanovic, M. and Kominiak, N. 52
- Swift, J.K., Greenberg, R.P., Whipple, J.L. and Kominiak, N. 87
- Swift, J.K., Tompkins, K.A. and Parkin, S.R. 74
- switch in games 177
- Symington, N. 105
- Symons, C. 455
- Symons, C., Khele, S., Rogers, J., Turner, J. and Wheeler, S. 454
- Symptom Checklist 90 (SCL-90) 476–7
- symptom measures,
- development of 476–7
- systematic case-based inquiry, use of 182
- systematic case studies 489, 490
- systematic desensitisation and exposure 120–21
- systematic treatment selection 286
- systemic change, gain of 15
- Systemic Clinical Outcome and Routine Evaluation (SCORE) 238
- Szasz, T.S. 284–5, 322
- T**
- Tacey, D. 260, 269
- Talbot, W. 71
- talk therapy out of doors 256–7
- talking about process 50
- talking and place to talk 15–17
- Talmon, S. 501
- Tanaka-Mastsumi, J. 348
- Tang, T.Z. and DeRubeis, R.J. 63
- Tangen, J.L. and Cashwell, C.S. 163
- tapestry in therapy 241
- Tarasoff, Tatiana 456–7
- task analysis 79
- task relevance 307–8
- Taylor, J.M., Kolaski, A.Z., Wright, H., Hashtpari, H. and Neimeyer, G.J. 525, 527
- Taylor, M. 381
- teacher, therapist as 30
- Teasdale, J.D., Segal, Z.V., Williams, J.M.G., Ridgeway, V., Lau, M. and Soulsby, J. 137
- Teasdale, John 137
- technical eclecticism 285–6
- advantages of 286
- techniques
- existential therapy 202–4
  - family therapy 234–8
  - interventions from established schools, use of 311
  - mastery of 411, 420



- technologies
  - delivery formats for better access and effect 513–17
  - new technologies and new types of person 529
- telephone counselling 513–14
- text messaging 516
- theatre of the oppressed 226–7
- Thematic Apperception Test (TAT) 100
- theories
  - case studies and building of 490
  - consensus within
    - transactional analysis, need for 173
  - culturally sensitive therapy, need for coherence in 360
  - embodied conversations, theoretical perspectives on 276–8
  - family therapy, traditions within 231–4
  - framework of, acquisition of 428
  - integration, integrated approaches and 288–91
  - pragmatic perspective on use of 304
  - of therapy, similarities across 282–3
  - tools, theories as 303–4
  - transactional analysis, foundations of 172–9
  - trauma theory of, embodied conversations and 276
- therapeutic process
  - agreement on goals 57
  - allegiance of therapist, factor in outcome research of 477
  - alternatives to psychiatric diagnosis 57
  - art in therapy, use of 247–9
  - assessment process 53–5
  - beginning therapy 46–61
  - behaviour change 65–6
  - case formation, contracting and 57–8
  - change, process of 63–4
  - change events and
    - processes, dichotomy between 63–4
  - client assessment of therapists 55
  - client homework, behaviour change and 66
  - client reasons for ending 85
  - community of self 69
  - contracting 57–8
  - conversation, core process of 49–50
  - courage 70–71
  - covert dimension of
    - process 80
  - diagnosis 55–7
  - dialogue 50
  - discussion topics
    - beginning therapy 61
    - ending therapy 89
    - hard work of therapy 82
  - dropouts 86–7
  - emotional processing 47
  - ending process
    - experience of 84
    - facilitation of 88
    - management of 87–8
  - engagement in therapy, readiness for 53–4
  - expectations, negotiation of 51–2
  - feedback, use of 78–9
  - finding what helps 71–6
  - focus of, quantification in maintenance of 132
  - framework for
    - understanding process 48–50
  - goals, agreement on 57
  - Goldilocks Effect 81
  - ‘hard work’ stage of therapy 62–82
  - helpfulness
    - client perceptions of 73–4
    - micro-analysis of 72–3
  - human quality in process 47
  - impact of ending on therapist 88–9
  - impass resolution 76–8
  - informed consent 51
  - innovative moments 70
  - intensity 70–71
  - intentionality 49
  - internal conflicts, dealing with 67–8
  - interpersonal process of starting therapy 59–60
  - interpersonal process recall (IPR) 80
  - learning and change in therapy 64–71
  - leaving therapy 83–90
  - management of endings, practical strategies for 87–8
  - metacommunication 50
  - metaphor, use in process 73
  - micro-analysis of
    - helpfulness 72–3
  - ongoing support, therapy without end 89
  - openness to new
    - experience 69–70
  - person-centred
    - therapies 158–9
  - planned behaviour
    - change 65–6
  - positioning 50
  - practical issues in starting therapy 51–9
  - pre-therapy assessment, rationale for formality in 53
  - preferences, negotiation of 52
  - preparation for ending 87
  - preparation for therapy 52
  - problematic experience, stages in assimilation of 68
  - process as sequence 49
  - process in therapy
    - literature 47
  - psychological
    - mindedness 53–4
  - reading suggestions
    - beginning therapy 61
    - ending therapy 90
    - hard work of therapy 82
  - recordings of sessions, benefits for clients
    - listening to 71

- reflection topics
  - beginning therapy 61
  - ending therapy 89
  - hard work of therapy 82
- religion and spirituality,
  - practice informed by 260–61
- resoluteness 70–71
- resolution of impasses 76–8
- self, community of 69
- session extension,
  - beginning therapy and 59
- staying on track 76–9
- talking about process 50
- task analysis 79
- therapeutic
  - communities 509
- therapy as process 47–8
- therapy goals, change
  - processes and 64–5
- therapy process factors 48
- time units 49
- transformative moments 78
- turn-taking 50
- types of ending 85–6
- unhelpfulness, client
  - perceptions of 75–6
- unplanned endings 86–7
- therapeutic relationship
  - alliance between client and therapist 31
  - Alliance in Action
    - scale 36–7
  - authentic meeting,
    - relationship as place of 29–30
  - author-editor
    - relationship 30–31
  - boundaried
    - relationship 41–2
  - building a relationship 36–9
  - building of 27–45
  - Clarkson's five relationship
    - model 32
  - client's internalisation of
    - therapist 34–5
  - coach, therapist as 30
  - cognitive-behavioural
    - therapy (CBT) 124–5
  - confrontation 39
  - countertransference 29
  - discussion topics 45
  - disengagement 39
  - embodiment of 39–41
  - financial relationship
    - 43–4
  - images of relationship,
    - reflection on 33–4
  - integrative models 31–4
  - Josselson's multi-
    - dimensional
      - model 32–3
  - management of, client's
    - perspective on 7
  - measurement of 42–3
  - metacommunication 38
  - mutual alignment,
    - maintenance of 31
  - person-centred
    - therapies 155–6
  - positive client-
    - therapist working
      - relationship 36–7
  - 'real relationship,' concept
    - of 34
  - reflection topics 45
  - relational depth 35
  - relational styles 32
  - relationship, therapeutic
    - significance of 42
  - relationship as
    - container 28–9
  - responsive
    - relationship 31–2
  - ruptures in alliances, repair
    - of 38–9
  - shared language 37
  - social behaviour, structural
    - analysis of 33
  - structural analysis of social
    - behaviour 33
  - teacher, therapist as 30
  - therapist 'types' 35
  - therapy room 40–41
  - transference 29
  - transition objects 39–40
  - unconscious
    - synchrony 37–8
  - withdrawal 39
- therapeutic significance
  - of gender 377–8
  - of relationship 42
- therapeutic space 17
- therapeutic structure,
  - maintenance
    - of security and consistency in 99
- therapeutic tasks in pluralistic
  - therapy 307–8
- therapeutic techniques,
  - psychodynamic
    - tradition of 97–100
- therapeutic writing 243–5
- therapist-client relationship,
  - deliberate and systematic use of 99
- therapist competence
  - dimensions of 411–22
  - making sense of 410–11
- therapist effects, research
  - on 471
- therapist self-awareness
  - enhancement of 435–40
  - theoretical frameworks
    - for 438
- therapist self-awareness,
  - disciplined use of 99
- therapist sexual behaviour,
  - dynamics of 465
- therapist 'types' 35
- therapist wisdom, nature
  - of 421–2
- therapist's perspective 13–26
  - aims of therapy 14–15
  - behaviour change, gain
    - of 15
  - behavioural experiments 24
  - challenging 21
  - checking out on
    - understandings 20–21
  - clarification 20–21
  - cognitive change, gain of 15
  - complex problems, making
    - sense of 19
  - counselling skills 20–21
  - discussion topics 26
  - elimination of symptoms,
    - gain of 14
  - empowerment, gain of 15
  - enlightenment, gain of 14
  - experience of being a
    - therapist 24–5

- therapist's perspective  
(*Continued*)  
 general principles of  
 therapy 15–20  
 individuation, gain of 14  
 insight, gain of 14  
 interventions, techniques  
 and 22–4  
 learning outcome 14  
 listening 20  
 meaning in life, gain of  
 finding 14  
 micro-skills 20–22  
 moral injury, gain in  
 address of 15  
 potential outcomes of  
 therapy 14  
 problem-solving experience,  
 gain of 14  
 psychological education,  
 gain in 14  
 reading suggestions 26  
 reduction of symptoms, gain  
 of 14  
 reflection 20–21  
 reflection topics 26  
 relating with others, gain  
 of 14  
 resolution outcome 14  
 restating meaning 20–21  
 restitution, gain of 15  
 safety and staying safe 19–20  
 self-acceptance, gain of 14  
 self-actualisation, gain  
 of 14  
 self-awareness, gain of 14  
 self-disclosure 21  
 silence 21  
 social action, gain in  
 generativity and 15  
 social involvement  
 outcome 14  
 social skills, gain in  
 acquisition of 15  
 specific therapist  
 practices 20–24  
 supportive relationship  
 18–19  
 systemic change, gain of 15  
 talking and place to talk  
 15–17
- therapeutic space 17  
 understanding therapy,  
 gain in 14  
 way of being 17–18  
 work of therapists 15–20
- therapy  
 'adapted' approaches  
 to 296–7  
 agencies and clinics 442  
 availability of, client's  
 perspective on 4  
 beginning therapy 46–61  
 being a therapist 407  
 common ground of 1–2  
 concepts as cognitive  
 tools 420  
 cultural difference and 317  
 difficult strands of 7  
 faiths and, therapy with  
 members of specific  
 faiths 263  
 feminist approach to 379  
 general principles of 15–20  
 goals, change processes  
 and 64–5  
 'hard work' stage of  
 therapy 62–82  
 'journey' of 10–11  
 practice of, conceptualisation  
 of 91–2  
 as process 47–8  
 process factors 48  
 research, range of 471  
 room for, therapeutic  
 relationship and 40–41  
 social adversity and 317  
 as social control, danger  
 of 530  
 spirituality and, barriers  
 between 261–2, 267  
 supervision of, functions  
 of 432  
 theories of, formulation  
 of 3–4  
 understanding therapy, gain  
 in 14  
 who can be a  
 therapist? 504–9
- third wave CBT  
 flourishing of 134–40  
 reflections on 139–40
- Thoma, N.C. and Cecero,  
 J.J. 22, 169, 193  
 Thomas, B.J., Roehrig, J.P. and  
 Yang, P.H. 37  
 Thompson, M.N., Graham, S.R.,  
 Brockberg, D., Chin,  
 M.Y. and Jones, T.M. 44  
 Thomson, M. 118  
 Thorne, B. and Sanders, P. 169  
 'threes,' thinking in terms  
 of, concept of 'third'  
 and 110  
 Thurin, J.M., Thurin, M. and  
 Midgley, N. 492  
 Tickle, E. and Murphy, D. 164
- time  
 concept of 342–3  
 considerations in delivery  
 formats 497–502  
 living in, existential therapy  
 and 197–8  
 structuring of, concept  
 of 173–4  
 time-limited dynamic  
 psychotherapy 113–14  
 time-limited therapy,  
 delivery formats  
 for 498–500  
 units in therapeutic  
 process 49
- Timulak, L. and Keogh, D. 488  
 Timulak, L. and McElvaney,  
 R. 487  
 Timulak, L., Belicova, A. and  
 Miler, M. 487  
 Timulak, L., Buckroyd, J.,  
 Klimas, J., Creaner, M.,  
 Wellsted, D., Bunn, F.  
 et al. 488  
 Timulak, L., McElvaney, J.,  
 Keogh, D., Martin, E.,  
 Clare, P., Chepukova, E.  
 et al. 167, 168  
 Timulak, Laco 23, 25, 63, 74,  
 168, 487  
 Tjeltveit, A.C. 447  
 Toivonen, H., Wahlström, J.  
 and Kurri, K. 60  
 Tolor, A. and Reznikoff, M. 54  
 Tomasello, M. and Carpenter,  
 M. 31

- Tompkins, K.A., Swift, J.K. and Callahan, J.L. 52
- Tonnesvang, J., Sommer, U., Hammink, J. and Sonne, M. 193
- TOPS self-report scale 478
- Torture, Foundation for the Care of Victims of 256
- Toto-Moriarty, T. 7, 114
- Totton, N. 396
- touch, ethical issues involved in use of 466–7
- Towbin, A.P. 506
- Tracey, J.G., Wampold, B.E., Lichtenberg, J.W. and Goodyear, R.K. 410
- training
- arts in, use of 430
  - assertiveness training 129
  - competence in therapists, professional structure for support of 426–31
  - counsellor training
    - programs in US 426–7
  - personal impact of therapy training 429
  - pluralistic therapy 314
  - post-qualification training 430–31
  - primary training 427–30
  - professional issues, training and 430
  - self-awareness and 399
  - skills training 427–8
- trance states 271
- transactional analysis 171–84
- analysis of transactions 176
  - basic assumptions 173–4
  - case study, TA in action 181
  - Cathexis Institute 180
  - classical school of 179
  - cognitive-behavioural TA 180
  - complementary transactions 176
  - con in games 177
  - contagious ego state 175
  - crossed transactions 176
  - crossup in games 177
  - discussion topics 183
  - drama triangle in games 177
  - ego state 174–5
  - ‘fairy tale’ characters in 178
  - formal theoretical propositions in 173
  - games 176–7
  - gimmick in games 177
  - International Transactional Analysis Association (ITAA) 181
  - life scripts 177–9
  - OK-ness, idea of 173–4
  - organisational structure of 181–2
  - payoff in games 177
  - persecutor in games 177
  - personal responsibility, centrality of 180
  - personality, structure of 174
  - practice of 179–81
  - ‘racket system’ in 178–9
  - reading suggestions 184
  - rededication school of 179–80
  - reflection topics 183
  - reflections on 182–3
  - relational TA 180
  - research and new developments in 182
  - response in games 177
  - second-order structures 175–6
  - strokes, motivational concept of 173–4
  - structural analysis 174–6
  - switch in games 177
  - systematic case-based inquiry, use of 182
  - theoretical consensus within 173
  - theoretical foundations of 172–9
  - time structuring, concept of 173–4
  - ulterior transactions 176
- Transactional Analysis Journal* 173, 181
- transcendent reality 260
- transdiagnostic approach in CBT 134
- transference 29
- concept in psychodynamic tradition 97
- transformative moments 78
- transition objects 39–40
- transition phase 6
- transpersonal psychotherapy 264–5
- trauma
- process of, evidence-based models of 460
  - theory of, embodied conversations and 276
- Trijsburg, R.W., Lietaer, G., Colijn, S., Abrahamse, R.M., Joosten, S. and Duivenvoorden, H.J. 22
- Trower, P., Bryant, M. and Argyle, M. 129
- Truax, C.B. and Carkhuff, R.R. 152, 156
- Truell, R. 429
- truth in existential therapy 199
- Trygged, S. 507
- Tryon, G.S. and Winograd, G. 57
- Tsai, M., Callaghan, G.M. and Kohlenberg, R.J. 71
- Tsai, M., Gustafsson, T., Kanter, J., Plummer Loudon, M. and Kohlenberg, R.J. 88, 148
- Tsai, M., Plummer, M.D., Kanter, J.W., Newring, R.W. and Kohlenberg, R.J. 147
- Tsai, Mavis 146, 147
- Tschuschke, V., Cramer, A., Koehler, M., Berglar, J., Muth, K., Staczan, P. et al. 22
- Tudor, K. and Widdowson, M. 181
- tummy rumbling 274
- turn-taking 50
- Turner, P.R., Valtierra, M., Talken, T.R., Miller, V.J. and DeAnda, J.R. 497
- Turner, Victor 271, 347
- two-chair work 190, 191–2
- Tyndall, N. 502

**U**

- Ulberg, R., Amlo, S., Hersoug, A.G., Dahl, H.S.J. and Hoglend, P. 114, 486
- Ulrich, R.S. 275
- ulterior transactions 176
- unconscious, importance in psychodynamic tradition 96–7
- unconscious synchrony 37–8
- understanding therapy, gain in 14
- unhelpfulness, client perceptions of 75–6
- unified psychotherapy 295
- Universal Declaration of Human Rights 399
- unmet need, pressures of 526–7
- unplanned endings 86–7
- unresolved attachment pattern 108
- utilitarianism 450

**V**

- Valkonen, J., Hanninen, V. and Lindfors, O. 10, 480
- values 447–8
- Van Bruggen, V., ten Klooster, P., Westerhof, G., Vos, J., de Kleine, E., Bohlmeijer, E. et al. 199
- Van Deurzen, Emmy 200, 202–3
- Van Eeden, Frederik 323
- Van Grieken, R.A., Beune, E.J., Kirkenier, A.C., Koeter, M.W., van Zwieten, M.C. and Schene, A.H. 76
- Van Manen, Max 202
- Van Renterghem, Albert 323
- Van Rijn, B. 182
- Van Rijn, B. and Wild, C. 182
- Van Rijn, B., Cooper, M. and Chryssafidou, E. 516
- Van Rijn, B., Cooper, M., Jackson, A. and Wild, C. 516
- Van Werde, D. 166
- Vanaerschot, G. 157, 165
- Vandenberghe, L., Coppede, A.M. and Bittencourt, M.V. 125

- Vandenberghe, L., Coppede, A.M. and Kohlenberg, R.J. 147
- VandenBos, G. 482
- Veale, D. and Wilson, R. 131
- verbal behaviour 344
- Verduin, F., Smid, G.E., Wind, T.R. and Scholte, W.F. 512
- Veseth, M., Binder, P.E., Borg, M. and Davidson, L. 483
- vicarious traumatisation 441
- video link communication 515
- virtual reality 516
- virtues 450–51
- Vlass, Eri 423
- Vocation Bureau 331
- vocational choice inventories 334
- voice quality 273
- voluntary counselling agencies 502
- Von Below, C. and Werbart, A. 76
- Von Bertalanffy, Ludwig 230
- Vos, J., Craig, M. and Cooper, M. 207
- Vromans, L.P. and Schweitzer, R. 218

**W**

- Wachholz, S. and Stuhr, U. 34–5
- Wachtel, P.L. 155
- Wade, N.G., Post, B.C., Cornish, M.A., Vogel, D.L. and Runyon-Weaver, D. 263
- Wagner, C.C. 136, 137
- Wagner-Moore, L.E. 187, 189
- Wahlström, J. 215
- Walck, D. 312
- Walfish, S., Barnett, J.E., Marlyere, K. and Zielke, R. 456
- Walker, C., Hart, A. and Hanna, P. 88
- Wallace, K. and Cooper, M. 434
- Walls, J., McLeod, J. and McLeod, J. 4, 52
- Walsh, K. and Hope, D.A. 389
- Wampold, B.E. and Imel, Z.E. 473, 483
- Wampold, B.E., Flückiger, C., Del Re, A.C., Yulish, N.E., Frost, N.D., Pace, B.T. et al. 483
- Wanigaratne, S. and Barker, C. 51
- Ward, E.C. 6, 55, 351, 356
- Warner, Mary S. 153, 164–5
- Warner's difficult process 164–5
- Warren-Findlow, J. 366
- Wartenberg, T. 196
- Watkins, C.E., Jr. and Campbell, V.L. 53
- Watkins, C.E., Jr. and Scaturro, D.J. 432
- Watson, Goodwin 282
- Watson, J.B. 117
- Watson, J.C. 155
- Watson, J.C., Goldman, R.N. and Greenberg, L.S. 168
- Watson, J.C., Steckley, P.L. and McMullen, E.J. 157
- way of being 17–18, 201
- Weakland, John 232
- weathering 366–7
- Weck, F., Jakob, M., Neng, J. M., Höfling, V., Grikscheit, F. and Bohus, M. 432
- Weiner, Norbert 230, 400
- Weissman, M.M., Markowitz, J.C. and Klerman, G.L. 144
- Weissman, Myrna 143
- well-being supervision and 434–5 of therapists 440–42
- Wells, A. 123, 138
- Wendt, D.C., Gone, J.P. and Nagata, D.K. 528
- Westbrook, D., Kennerley, H. and Kirk, J. 128
- Westen, D., Novotny, C. M. and Thompson-Brenner, H. 133–4, 476
- Western ideas, relevance in Islamic societies 356–7
- Western society, nature of change in 320



- Westmacott, R. and Hunsley, J. 87
- Westmacott, R., Hunsley, J., Best, M., Rumstein-McKean, O. and Schindler, D. 85
- Westra, H.A. and Arkowitz, H. 137
- Westra, H.A., Aviram, A. and Doell, F.K. 136
- Westra, H.A., Aviram, A., Barnes, M. and Angus, L. 7, 52
- Wexler, D.B. 467
- Wheatley, J. and Hackman, A. 130
- Wheeler, A.J. and McElvaney, R. 441
- Wheeler, G. 188
- Wheeler, S. and Richards, K. 434
- Whiston, S.C. 53
- Whitaker, R. and Cosgrove, L. 56
- White, M. and Epston, D. 211, 212–13, 213–14, 232
- White, Michael 210, 211, 212–13, 214–15, 215–16, 217
- White, W.L. 58, 179, 417, 429
- Whiting, J.B., Nebeker, R.S. and Fife, S.T. 453
- Whittal, M.L. and O'Neill, M.L. 131
- Wicks, R. and Buck, T. 441
- Widdowson, M. 182, 481
- Wigg, R., Cushway, D. and Neal, A. 436
- Wiggins, S. 163
- Wiggins, S., Elliott, R.E. and Cooper, M. 163
- Wilber, Ken 264
- Wilce, J.M. 347
- Wild, J. and Clark, D.M. 130
- wilderness therapy 254–5
- Wildflower, L. 334
- Wilensky, J.L. and Wilensky, H.L. 332
- Willi, Jurg 237
- William Alanson White Institute 143
- Williams, D. and Levitt, H.M. 80, 448
- Williams, E.N. 435
- Williams, J.M.G. 123
- Williams, J.M.G. and Penman, D. 130
- Williams, J.M.G., Duggan, D.S., Crane, C. and Fennell, M.J.V. 137
- Williams, M., Teasdale, J., Segal, Z. and Kabat-Zinn, J. 137, 517
- Williams, Mark 130, 137
- willingness (and capacity) to connect 6–7
- willingness to be known 157
- Willis, A. 257
- Wills, T.A. 44, 126, 505
- Wilson, D.M. and Cash, T.F. 519
- Wilson, J. and Giddings, L. 10
- Wilson, M. and Sperlinger, D. 89
- Wingard, B., Johnson, C. and Drahm-Butler, T. 217
- Winnicott, D.W. 39–40, 95, 102, 106
- Winnicott, influence of D.W. 106
- Winslade, J.M. 50
- Winter, L.A. 405
- Wisconsin experiment 152–3, 166
- wisdom 451
- withdrawal 39
- Wittgenstein, Ludvig 222
- Woldt, A.L. and Toman, S.M. 187
- Wolpe, Joseph 118, 120, 473
- women's development, relational nature of 383
- Wong, A.J., Nash, M.R., Borckardt, J.J. and Finn, M.T. 192
- Wong, Y.J. 451
- Wong, Y.J., Owen, J., Gabana, N.T., Brown, J.W., McInnis, S., Toth, P. et al. 520
- Wood, E.C. and Wood, C.D. 54, 85
- Woollams, S. and Brown, M. 173, 179
- Worell, J. and Remer, P. 381
- work of therapists 15–20
- Working Alliance Inventory 485–6
- working alliances  
creation of 125  
model for person-centred therapies 163  
studies of 485–6
- working together 7
- workplace structures,  
fundamental  
transformation of 321
- World Health Organization (WHO) 56
- world of counselling and psychotherapy,  
challenges within 525–6
- worth, conditions of 154
- 'wounded healer' model 416–17
- writing  
art in therapy, use of 243–5  
cognitive aspect of 244  
creative writing 244–5  
physiological aspect of 244  
poetry writing 241  
social aspect of 244  
therapeutic writing 243–5
- Wubbolding, R.E. 289
- Wyatt, J. 157, 266
- X**
- Xiao, H., Castonguay, L.G., Janis, R.A., Youn, S.J., Hayes, J.A. and Locke, B.D. 86
- Xiao, H., Hayes, J.A., Castonguay, L.G., McAleavey, A.A. and Locke, B.D. 86
- Xu, H. and Tracey, T.J.G. 528
- Y**
- Yager, J. and Feinstein, R.E. 428
- Yalom, I.D. 23, 200, 206, 286, 308, 511–12

- 'missing ingredients'  
of 203–4  
Yontef, G.M. 188, 189, 192  
Young, J., Weir, S. and Rycroft,  
P. 502  
Young, J.E., Klosko, J.S. and  
Weishaar, M. 138  
Young, Jeffrey 138  
Younggren, J.N. and Gottlieb,  
M.C. 463  
YouTube 15
- Z**  
Zajonc, R. 138  
'Zeigarnik effect' 187  
Zerubavel, N. and Wright,  
M.O. 416–17  
Zhang, L. 528  
Zhao, J.B., Ji, J.L., Yang, X.L.,  
Yang, Z.Z., Hou, Y.F. and  
Zhang, X.Y. 468  
Zheng, P., Gray, M. J., Zhu, W.Z.  
and Jiang, G.R. 468
- Zhu, S.-H. and Pierce, J.P. 499  
Ziller, R.C. 243  
Zimmermann, D., Rubel, J.,  
Page, A.C. and Lutz,  
W. 86  
Zur, O. 462  
Zuroff, D.C., Koestner, R.,  
Moskowitz, D.S.,  
McBride, C., Marshall,  
M. and Bagby, M.R. 4,  
510











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